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ORIGINAL ARTICLES.

A CASE OF FRACTURE OF THE TWELFTH DORSAL VERTEBRA, FOLLOWED BY INJURY TO THE SPINAL AND SYMPATHETIC NERVE-SUPPLY OF THE BOWEL IN THE REGION OF THE ILEO-CECAL VALVE:

Intestinal Hemorrhage and Death on the Seventh Day.¹

By J. T. ESKRIDGE, M.D.,
OF DENVER, COLORADO.

M. J. A., male, thirty-three years of age, born in Illinois, by occupation a carpenter, a robust, muscular fellow, had enjoyed excellent health until the time of the accident that was the cause of his death. On July 9, 1890, whilst engaged in work on a large nine-story building in Denver, a cage with its contents of brick, weighing about two thousand pounds, as it was passing over him only a few feet above his head, fell, striking him on the crown of the head, and carrying his head between his feet and bending the spine sharply backward in the dorso-lumbar region. The rope by which the cage was suspended did not allow it to descend nearer the floor than about eighteen inches. The man was imprisoned between the cage and the floor only a few minutes, but when released he was unconscious and remained so about half an hour. On regaining consciousness his legs felt numb and were paralyzed for two hours. He was removed to the Arapahoe County Hospital, where I saw him four hours after the occurrence of the injury. An examination showed that there were neither paralysis, sensations of numbness, nor loss of tactile sense in any portion of the body or limbs. There was no incontinence of urine, but he was unable to expel the contents of the bladder. The back, at the junction of the dorsal and lumbar vertebrae, was arched backward and the soft tissues over the upper lumbar and four lower dorsal spines were greatly swollen and acutely sensitive to the touch. He complained of great pain in this portion of the back and said that he had uncomfortable sensations in the lower portion of the abdomen. His temperature was 100.4° ; the pulse, 100; respiration, 24. A cloth saturated in a lotion of equal parts of laudanum, arnica, and aconite (tincture) was applied over the sensitive portion of the back, and a surface, ten by four inches, was covered with a thick ice-poultice (equal parts of pounded ice and bran). His suffering was so great that it required half a grain of morphine, hypodermatically, to relieve it. The next morning he was

feeling quite comfortable. The back was free from pain so long as he was left undisturbed. He evacuated his bladder without assistance. The urine was free from albumin and sugar. He enjoyed his breakfast, which consisted of eggs, toast, and milk. His temperature was now 100.4° ; respiration, 18; and pulse, 80. In the evening his temperature went up to 101° , but he felt comfortably and ate well. No morphine had been required since the night of his admission into the hospital. The ice-poultice was continued.

During the next four days he continued to improve. His temperature varied from 99° to 100.3° . He ate well and had no difficulty with the bowels or bladder. By the end of the fifth day (July 13th) the swelling and tenderness in the back had nearly all disappeared, and slight crepitus could be detected over the spine of the twelfth dorsal vertebra. The temperature in the morning was normal and in the evening was 99.5° . The improvement continued until about noon of the sixth day after the accident, when he ate quite freely of boiled cabbage, which, contrary to orders, had been served to him by one of the porters of the hospital. Two hours after partaking of the cabbage he began to vomit and continued to do so every few minutes for several hours. The vomitus, at first, consisted of undigested food, including cabbage, then of mucus, and lastly of a dark coffee-grounds-looking substance. He complained of great pain in the stomach and in the lower portion of the abdomen. His strength failed rapidly, and the next morning he was in a state of profound collapse. I saw him at 11 o'clock. His temperature was 101° ; pulse, 160; and respiration, 48. His bowels had been opened twice the day before, after eating the cabbage, but not at all that morning. His abdomen was irregularly and greatly distended, especially from the umbilicus downward and to the left. Death took place twenty minutes later (11.20 A.M.), consciousness continuing to the last.

Secutio cadaveris at 12.30 P.M., one hour after death, in the presence of Drs. Davis, Boice, and Baker. The brain was not examined. The heart and lungs were nearly normal in appearance and free from disease. On opening the abdominal cavity no peritoneal inflammation was found and the cavity did not contain an undue amount of fluid. On superficial inspection, the stomach, bowels, and other viscera presented a normal appearance, except the lower portion of the ileum and the upper portion of the colon. This portion of the bowel was enormously distended, almost black in color, and accounted for the irregular distention of the abdomen that I had observed a few minutes before death. The stomach was not inflamed, but it contained several ounces of watery fluid stained with blood. On slitting open the small intestine from above down-

¹ Paper read at the meeting of the American Neurological Association, held in Washington, D. C., September 22-25, 1891.

ward, nothing abnormal was found except a small quantity of fluid colored like that found in the stomach, until the lower portion of the ileum was reached. At a point five inches above the ileo-cecal valve, the bowel was abruptly distended to its utmost, and the swollen mucous membrane seemed to completely occlude the caliber of the bowel at this point, so that none of the contents of the distended portion of the intestine could reach the undistended portion. The distention reached from a point in the ileum five inches above the valve to a point in the colon six inches below the valve, and ended as abruptly below as it had begun above, and the swollen mucous membrane below prevented the escape of the contents of the distended bowel into the gut below as effectually as was the case at the upper portion of the distention. A ligature was thrown around the bowel above and below the distended portion, which was excised for further examination. The remaining portion of the colon was examined and found normal. It was not stained with blood. The intestine immediately above and below the seat of distention seemed contracted and considerably smaller than normal. On examining the excised portion of the bowel, which was of a bluish-black color, it was found to be eleven inches in length and six inches in diameter at the seat of greatest distention, a point just below the ileo-cecal valve. This portion of the bowel contained a little over two quarts of dark, semi-fluid blood. The mucous membrane and other coats of the bowel were almost black, soft, and everywhere infiltrated with dark, fluid blood. The vermiform appendix was dark and everywhere infiltrated with blood, but its blind pouch was not enlarged. None of the other viscera of the abdomen presented anything abnormal.

On exposing the spinal column, both in front and behind, the bone-lesion was found to involve the twelfth dorsal vertebra. After examining the cord, the sixth dorsal and lower lumbar vertebrae were sawn through and the intervening portion of the spinal column with the posterior third of the lower five ribs was removed and a careful dissection made. The soft parts around the body of the twelfth dorsal vertebra were considerably infiltrated with blood and inflammatory products. The twelfth thoracic ganglia of the sympathetic nerve, one of which lies on either side of the body of the vertebra, were surrounded by bloody infiltration and inflammatory products. The ganglia themselves were discolored, softer than normal, and apparently partially or completely disorganized. It was impossible to dissect out the ganglia owing to the infiltration of the parts and to their disorganized condition, hence they could not be obtained for microscopic examination. On further dissection it was found that the anterior portion of the body of the twelfth dorsal vertebra was crushed and a horizontal fracture extended through the entire body of the vertebra, and allowed the bodies of the eleventh dorsal and first lumbar vertebrae to approach anteriorly within half an inch of each other. There was also a backward subluxation of the upper portion of the twelfth costal vertebra, exposing the two superior articular processes of the

vertebra, which projected backward nearly half an inch further than the inferior articular processes of the eleventh costal vertebra. As well as could be determined, the ligamentum subflava, the supra-spinous, inter-spinous, and capsular ligaments between the eleventh and twelfth costal vertebrae were ruptured. The ends of the spinous processes of these two vertebrae were separated a distance of about two inches from each other, causing a sharp curve in the spinal canal. The size of the spinal canal was further lessened by the projection backward of the upper and posterior portion of the body of the twelfth costal vertebra. The spinal cord was stretched and flattened from before backward by the angular curvature of the spine and by the fragment of bone projecting into the canal. Only a few drops of blood were found in the spinal canal. Neither the cord nor membranes seemed to be congested or inflamed. The spinal nerves were not compressed by the displaced or fractured bone. That the functions of the cord had been only temporarily affected by the accident, was substantiated by the symptoms. Had the patient survived the accident a few weeks or months, meningitis (local) and myelitis (transverse) would have been the inevitable results of compression and caries.

This is not the time or place for extended comments on the above case, which, so far as my information goes, is unique. I am not aware that any case has been previously recorded illustrating the spinal and sympathetic nerve-supply to the bowel in the region of the vermiform appendix and ileo-cecal valve. The twelfth pair of thoracic sympathetic ganglia receive fibers from the eleventh pair of dorsal nerves, and none from any other of the spinal nerves, if the illustrations in Gray's *Anatomy* are correct. In works on anatomy considerable is said about the distribution of the branches of the sympathetic nerve, but almost nothing, so far as the contents of the abdomen are concerned, in regard to the localization of the spinal and sympathetic nerve-supply of any viscus or portions of the hollow viscera. It is probable that irritation of the eleventh thoracic and first lumbar sympathetic ganglia, caused by infiltration of blood in the soft parts, was the cause of the contraction of the bowel immediately above and below the distended portion. The contraction was so great in the colon immediately following the seat of distention that it made this portion of the bowel appear like a piece of the small intestine.

That internal hemorrhage was the immediate cause of death I do not think there can be any doubt. The cause of the hemorrhage may not, in the opinion of some, be so easily accounted for. It seems to me that in the absence of any other apparent cause, the injury to the twelfth thoracic sympathetic ganglia (which contain both spinal and sympathetic fibers, the one supplying the muscular coats of the bowel and the other the bloodvessels,

glands, etc.), is sufficient to account for the muscular and vasomotor paralysis of the bowel; and probably the irritation set up by the presence of the cabbage and the general disturbance caused by the vomiting were all factors in producing the fatal and localized hemorrhage.

DIABETES MELLITUS GRAVIDARUM.¹

BY HENRY D. FRY, M.D.,
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GRAVIDITY increases the susceptibility of woman to certain diseases, and often changes the type of the malady by accentuating its dangers.

The physiological changes in the blood, in the secretions and excretions, and the nervous and physical alterations that occur in normal pregnancy, present new soil for the development and growth of pathological conditions.

The significance of changes in the urinary excretion is generally limited to considerations of the danger of convulsions. The presence of albumin and casts in urine, with low specific gravity and deficient elimination of solid ingredients, are the changes that warrant such a conclusion. Attention, at present, is claimed by the importance of different alterations: increased flow of urine, increased specific gravity, and the presence of sugar. Augmented flow of urine, with consequent low specific gravity, is considered a normal condition of pregnancy. The presence of sugar in small quantity was found by Blot to exist in one-half of all pregnant women. All nursing and lying-in women had glycosuria, and the proportion of sugar in the urine bore some relation to the activity of the mammary glands. When lactation ceased the sugar disappeared. Diabetes insipidus has been observed to occur during, and apparently dependent upon, pregnancy. Conjugal diabetes is described as a form of the disease affecting husband and wife simultaneously.

Physiological glycosuria and different forms of diabetes must not be confounded with diabetes mellitus gravidarum. Under the title "Puerperal Diabetes," Matthews Duncan reported several cases of his own and as many others as he was able to collect. The report comprises the histories of twenty-two pregnancies in fifteen women, and a study of these contributes mainly to the deductions formed in the present article.

The following case came under the observation of the writer:

The first pregnancy and labor were normal. Diabetes developed about the fifth month of the second pregnancy, followed by death of the child

at the seventh month. Premature labor followed, and the mother died on the fifth day.

Mrs. P., thirty-one years of age, a secundipara, with good family history, gave birth to her first child after a normal pregnancy and labor. Subsequently her health remained good, but she was unable to nurse her baby, as the milk did not agree with it. In June, 1880, she became pregnant a second time. In the early part of October she first noticed that she was troubled with thirst, but attributed it to the warm weather. Frequent desire to pass urine next attracted her attention, and this symptom increased until the middle of October. She complained of being easily tired and had great difficulty in walking. In the latter part of October, and several times during November, she suffered from what were supposed to be bilious attacks.

The patient came under the writer's observation on November 18, 1880, complaining of severe headache, slight nausea, and constipation. A specimen of urine, that had been requested for examination, was sent on November 23. Seventy-four ounces had been passed in the twenty-four hours, with a specific gravity of 1045. There were no casts or albumin, but it contained 9 per cent. (nearly half a pound daily) of sugar. Dietetic and medicinal treatment were prescribed. After the latter part of November she was more easily tired, and expressed anxiety about her condition. She went out daily until the early part of December, but spent much of the day lying on the lounge. Dyspnea was complained of on slight exertion and was noticeable in talking. She also complained of a stuffed feeling in the ears and of nausea, which were relieved by the recumbent position. A bright, circumscribed spot was generally visible upon one or other cheek—usually the left. Her pulse was 120, appetite poor, skin dry, and mouth dry and sticky. The average daily excretion of urine and proportion of sugar contained, from November 24th to December 10th, inclusive, were ascertained to be as follows: urine, 79 ounces; sugar, 5 per cent. December 10th, emaciation and weakness increased and breathing more difficult. Weight seven pounds less than in August. December 11th, patient passed a miserable night, and her husband, being alarmed about her condition, sent for me at 9 A.M. I found the pulse rapid and feeble; the breathing short, and the speech jerky. The fetal heart-sounds could not be distinguished. Examination revealed the head presenting, cervix effaced, and os dilated as large as a silver dollar. Labor pains had not been felt. Her condition was so serious that an appointment was made to meet Dr. Busey at 2 o'clock in the afternoon to consider the advisability of emptying the uterus. At 11 o'clock an urgent summons was sent to return to the house, and on arrival I found the head of the infant born. The birth had been painless, and the only sign to attract attention to the fact that labor was progressing was the discharge of liquor amnii about an hour before its termination. The body of the child was delivered and the placenta readily extracted. The uterus contracted well, and very little blood was lost. The infant, a male, was small but well nourished. It had evidently been dead

¹ Abstract of paper read at meeting of American Gynecological Society, held in Washington, D. C., September 22-24, 1891.

for some days, as the epidermis peeled off easily. The mother was greatly prostrated; pulse 150, and feeble, and extremities cold. She was wrapped in blankets, hot applications applied, strophanthus and whiskey given by the mouth, and later, hypodermatic injections of whiskey and digitalis. An injection of morphine and atropine was also administered hypodermatically. The patient slept some, felt relief, but still complained of shortness of breath. At 2 o'clock Dr. Busey saw the case in consultation, and continued to meet and advise with me daily. Stimulants and warm applications were continued, and two and a half grains of extract of ergot in suppository were given every four hours. During the day the pulse was from 120 to 130, axillary temperature 98.2°, and surface cool. Thirst was a prominent symptom; the urine passed in large quantities; the breathing was less labored; the lochia normal; the mind dull, but when aroused, clear. On December 12th the symptoms were milder, and on the 13th the pulse was weaker, the temperature normal, the abdomen tympanitic. In the afternoon the mind was dull and one eye half opened in sleep. The mental condition was that of low typhoid. On December 14th the bowels were moved three times from the effect of calomel triturations. The abdomen was tympanitic. Milk diet was stopped and she was given animal broths and scraped raw beef. The mind became heavier; temperature 99.7; lochia normal. On December 15th the condition was worse; respirations were deep and labored, but not accelerated; eyes retracted; clonic contraction of muscles of chest and arms. At 10 A.M. she was unconscious, almost pulseless, and later in the day died.

FREQUENCY AND DIAGNOSIS.—Judged by the paucity of literature on the subject, we might infer that diabetes occurring during the child-bearing period is an extremely rare complication. We believe, however, that the disease is not so uncommon as it is unrecognized. It may develop during pregnancy, the latter exercising a causal influence, or pregnancy may occur in a woman already diabetic. That peculiar condition of a pregnant woman that is responsible for the development of the disease in one case is likely to be the factor in adding malignancy to a preëxisting mild attack in the other. In explanation of the presumable infrequency of the occurrence of pregnancy in diabetic women, it is asserted that the disease exercises a direct influence upon the female generative functions, producing diminution of sexual energy. Local diseases, inflammatory in character, are common in diabetic women and may lead to sterility. That the complication may occur more often than we are led to suppose, and be overlooked, is evident from the histories of the cases collected by Matthews Duncan. In the first case met with by that observer, the urine was not examined for sugar until after labor, although well-marked symptoms of diabetes were present and the patient's appearance created the

gravest alarm. There were marked thirst and polyuria, but it was not until the day after labor that the urine was examined for sugar and its presence revealed the nature of the malady. Death occurred two days later. In many other reported cases the disease was unrecognized, and in some of them during repeated pregnancies, although well-defined symptoms pointed to the probable existence of glycosuria.

In W. L. Reid's case the symptoms of the disease were well marked during pregnancy, and after labor the thirst became so "frightful" that the woman crept on her hands and knees to the water-bottle. Two months afterward her emaciation and weakness led to the suspicion that she was suffering from diabetes. Examination showed that she was passing twenty-two ounces of sugar in the twenty-four hours.

DIAGNOSIS.—To aid in recognizing the affection, glycosuria should be suspected and the urine examined for sugar in all cases of pregnancy presenting obscure symptoms, weakness, emaciation, short breathing, etc. It is a good rule to suspect diabetes whenever a dead child is born without apparent cause. Syphilitic poison is no more certain to destroy fetal life than the diabetic condition. The subjective symptoms of the affection are of little diagnostic value, because they seldom attract the attention that their importance demands. When a woman is suffering from diabetes under other circumstances she consults a physician about her ill-health, but when occurring during pregnancy, the symptoms are made light of, attributed to other causes, or considered incidental to her condition. In my case the patient did not complain of any symptom that led to a suspicion of diabetes, although the disease had undoubtedly existed a month before she came under observation. The diuresis was attributed to the thirst, and the thirst to the warm weather. The importance of the symptoms in connection with her ill-health was not suspected.

In several of the reported cases, disturbance of vision led to the detection of glycosuria.

From the evidence that cases have been overlooked and others accidentally discovered, it is more than likely that diabetes occurring during pregnancy is often unrecognized. Some fatal cases are probably classed among deaths due to unaccountable causes, to shock, embolism, the entrance of air into the veins, etc.

Before taking up for consideration the effect of diabetes upon the pregnant, parturient, and puerperal woman, attention is again called to the influence of the child-bearing process upon the disease. When a predisposition exists to diabetes, pregnancy is liable to act as an exciting cause. It may develop in the beginning of gestation, or be deferred until later, usually about the period of quickening. When

preëxisting, the type of the malady is changed for the worse. The disease is less responsive to treatment than under other circumstances. If, however, it do not progress to a fatal termination before confinement, some hope may be entertained that a favorable change will take place at the end of pregnancy. Often the improvement is marked, and the disease seems held in abeyance until a succeeding pregnancy or some other cause starts it up with renewed activity. Cases are reported of disappearance of sugar from the urine after labor, and with it of diabetic symptoms. Some of the patients remained in good health, while others suffered relapses in a few months, or in subsequent pregnancies.

The aggravation of diabetes by pregnancy sometimes causes the disease to assume an acute form. In the case reported by myself, the duration of the disease, from the appearance of the symptoms to the fatal termination, was only ten weeks.

Other cases reported present well-defined attacks of the intermittent type. Authorities on the subject contest the existence of an intermittent diabetes, and attribute cases reported as such either to the result of malarial poisoning or to a benign type of diabetes, in which sugar disappears temporarily, and reappears on slight provocation. The case mentioned by Bennowitz is stated to be unique in this respect. Other cases of intermittent type are reported by Matthews Duncan, John Williams, and F. A. Packard, which confirm the statement that diabetes, occurring in the child-bearing woman, may assume an intermittent form, notwithstanding the admitted rarity of that type of the disease under other circumstances.

THE EFFECT OF DIABETES ON PREGNANCY, LABOR AND THE PUERPERIUM.—In studying this part of the subject one is immediately impressed with the pernicious influence exerted by the disease upon the function of child-bearing. Pregnancy is frequently interrupted by miscarriage or the premature birth of a dead child. The death of the fetus generally occurs at about the seventh month, but the fetus may not be expelled for one or two months afterward. Excessive development of the child is mentioned in a number of cases. It is impossible to state the exact proportion of pregnancies that end in miscarriage and premature labor, because of the incomplete information furnished in the reported cases. Seventeen women who were affected with diabetes at some time of their child-bearing period, gave a total number of seventy-nine pregnancies. The result was not mentioned in thirty-seven pregnancies. Of the remaining forty-two pregnancies only twenty (48 per cent.) terminated naturally. In two of these the children were feeble and died soon afterward; nine, or 21 per cent., of the pregnancies, ended in

miscarriage, and thirteen, or 30 per cent., in premature death of the child. While demonstrating the harmful effect of diabetes upon pregnancy these figures do not represent the exact state of the case. Some of the pregnancies included in the above list occurred in women before they became diabetic; and, on the other hand, it is likely that the result, in most of the thirty-seven cases not mentioned, was normal.

Labor at term, in a diabetic woman, does not appear to deviate from the normal, except when influenced by the large size of the child and excessive quantity of liquor amnii.

Complications arising from a distended bladder are liable to occur during labor and the puerperium.

In cases that change for the better after confinement the symptoms improve in a few days. Sugar disappears from the urine (except the small amount considered physiological) after the first week—sometimes almost immediately. Cases recovering after labor should be carefully watched to prevent a relapse of the disease.

The symptoms after labor in severe cases of diabetes, especially when the child is dead, are those of exhaustion and threatened collapse. The pulse is feeble, and varies from 120 to 150, or more. The surface and extremities are cold. The temperature is normal or subnormal until the approach of the fatal termination, when it rises to 100° or 101°. The labored respiration is generally relieved after the birth of the child. The mental condition is generally blunted, the patient talks incoherently, and is restless. Death is generally preceded by coma for from a few hours to several days.

PROGNOSIS.—The unfavorable prognosis of diabetes is accentuated by the coëxistence of pregnancy. Mild cases assume acute forms, and acute cases rapidly progress to a fatal termination. To this general statement exceptions are met, and cases remain mild and extend through repeated gestations. When the disease exists to an degree sufficient to cause the death of the child the gravest apprehension must be felt for the safety of the mother. Of ten such cases, nine died within eight months after labor, and only one survived with persistent diabetes. The birth of a healthy child at term, in a diabetic woman, indicates that the disease has not reached a critical stage. In such cases, therefore, a favorable prognosis may be given so far as immediate danger is concerned.

Intercurrent diseases during pregnancy or the puerperium possess additional gravity.

The great danger to the child's life has already been stated. Over half of the pregnancies ended in miscarriage or premature death of the child.

An important question now comes up for con-

sideration. Should a woman marry who is suffering from diabetes? From the evidence that has preceded the reply must be in the negative. The disease under favorable conditions, and with proper medicinal and dietetic treatment, holds out encouragement of a comfortable existence for several years at least. The intervention of pregnancy would remove any favorable conditions that were present, and jeopardize the expectancy of a life that at best is none too good. It is even questionable if marriage be advisable in a woman who has a strong hereditary predisposition to diabetes.

TREATMENT.—The obstetrical treatment of this subject pertains to a consideration of the advisability of the induction of premature labor. The question is entirely a new one, and we have not sufficient knowledge at hand to decide it. In the milder cases of the disease, when there is reason to think that pregnancy will terminate naturally, interference is not justifiable. But when the symptoms are acute, rapid emaciation and exhaustion of the mother threatening the existence of the child, prompt action is demanded in the interest of both. The period at which the child usually succumbs is about the seventh month; labor must, therefore, be induced at the earliest period of viability.

SUPPLEMENTAL TREATMENT OF THE PARALYSIS OF ACUTE ANTERIOR POLIOMYELITIS.¹

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THE frequency with which cases of paralysis dependent upon poliomyelitis apply at an orthopedic hospital for treatment suggests to me the propriety of presenting to the Fellows of the American Orthopedic Association a paper on the subject of acute anterior poliomyelitis.

With the pathology and the clinical history of the affection I have on the present occasion nothing to do. I have long since become acquainted with a point in the therapeutics of this affection, a point with which all my hearers are more or less familiar. It is this: A palsied muscle or a group of palsied muscles is often very much handicapped by contracted tendons or muscles on the opposite side of the limb. Because of these contractures local treatment is often inefficient. However efficient the galvanic or the faradic current or even massage may be, if the muscle is overstretched this efficiency is certainly minimized. Another point that has forced itself upon me is this: A palsied muscle or a group of palsied muscles responds better to local treatment after a period of rest, or, at least,

after being retained for a long time in normal position. These points can be illustrated better, I think, by the narration of a few cases taken at random from my notes.

CASE I.—A girl, fourteen years of age, was admitted to the hospital on January 10, 1888. The diagnosis was paralytic talipes equinus. She gave the usual history—the fever came on when she was twenty-one months of age, followed on the next morning by paralysis. She had the usual out-patient treatment. At the time of her admission, then twelve years after the date of the paralysis, the heel of her right foot was raised several inches from the floor, the toes were hyper-extended, and she bore her weight on the distal extremity of the metatarsal bones. Any attempt at dorsi-flexion of the foot caused hyper-extension of the toes, the flexion of the foot being resisted by a shortened tendo Achillis. The calf measured $10\frac{1}{2}$ inches, as against 14 for the opposite side. While there was no absolute paralysis of the perineal group, there was certainly paresis, with apparent paralysis of the anterior tibial group. Two days after admission the tendo Achillis was divided, and the foot immediately flexed to a right angle, the space between the severed ends of the tendon being about $1\frac{1}{2}$ inches. A convex pad was placed over this space to avoid the pressure of the bandage, the foot and leg encased in plaster-of-Paris, which was not removed until eleven days after the operation. The deformity was then over-corrected; another plaster bandage was applied, and, on the 8th of February, a steel apparatus without any joint at the ankle was used for convalescence. This enabled us to afford the palsied group of muscles rest, and on the 9th of April the girl was able voluntarily to flex the foot beyond an angle of 90° .

CASE II.—A boy, eleven years of age, presented paralysis of the right lower extremity, with anterior tibial paralysis of the left side. He was six years of age when attacked with poliomyelitis, and for at least a year after the attack was unable to stand. He moved about on crutches; finally contractures appeared, and for a year or two it was very difficult for him to walk with crutches. There was very marked lordosis, and in the dorso-lumbar region a lateral curvature to the right side; he bore his weight on the left limb, the right limb being practically a dangling leg. The anterior tibial muscles on the right side were very nearly powerless, and the quadriceps femoris was weak. The thigh-flexors on the left side, as well as the leg-flexors, were very nearly completely palsied, although the boy was able to move the knee and hip-joints with the assistance of associate muscles. The thigh-flexors, including some of the deeper fascia, were shortened, and it was impossible to extend the thigh beyond an angle of about 135° . Under ether, on the 29th of September, an open incision was made just below the anterior superior spinous process, and pretty free division of the muscles and fascia made, until the limb could be brought down to an angle of about 160° . The tendo Achillis was divided, and the leg was put up in plaster-of-Paris. On October 30th, under ether, a still further correction of the de-

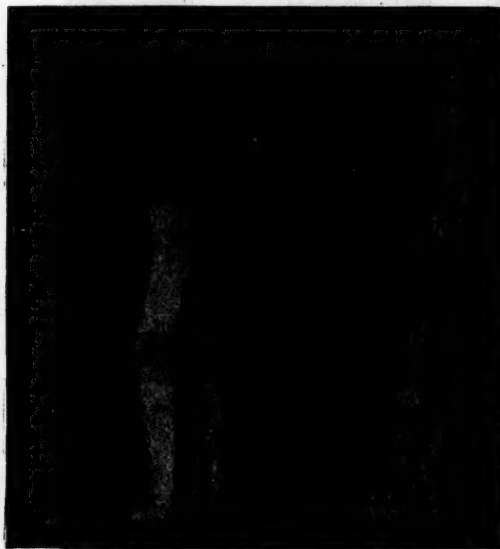
¹ Read at the meeting of the American Neurological Association held in Washington, September, 1891.

formity was made, this time by manual force. On the 14th of February, 1889, the boy was discharged, able to walk without crutches, but with the limb supported at the knee by apparatus. While no electrical tests were employed in this case, it was the general impression of the hospital staff, as well as of the patient's friends, that he had much better control of his muscles than before the operation.

CASE III.—The following case got about the hospital the soubriquet of the "Kangaroo Case." He was a boy, eight and a half years of age, referred to me by a distinguished orthopedic surgeon, in order that I might give him a home. A good many physicians and surgeons still hold to the idea that the hospital is a kind of a home for incurables. This boy's case seemed so interesting to me that, on November 26, 1888, I gladly admitted him to the hospital, and placed him under treatment in the wards. He presented the following history: When eighteen months of age he had "pneumonia," which lasted a month. On recovery it was found that his legs and arms were paralyzed. The arms gradually recovered power, the left leg improved a little, the right not at all. Three or four years later, he had a second attack, so the mother reports, and another attack last winter. I found his body and upper extremities well developed. He was unable to stand; the lower limbs

degree of genu recurvatum. I have not transcribed the comparative measurements, because they are unimportant. Under ether, on the 18th December, 1888, I made a vertical incision, one and one-half inches in length, just below each anterior superior spinous process, and while an assistant attempted to extend the thighs I divided with a scalpel and scissors (using my fingers as probes) all muscles and fascia offering resistance. I found that I came quite down to the capsular ligaments. I made counter-openings behind the major trochanters, and for drainage inserted a small strip of iodoform gauze, closing the primary incisions with catgut. By this time I was enabled to extend the thighs to an angle of 180° , bringing them down parallel, and after putting on a full antiseptic dressing I applied a plaster-of-Paris bandage extending from the axilla to the balls of the feet. By the 18th of January, the incisions had entirely healed, and without any apparatus the limbs lay parallel in bed. I soon put on a pair of long springs, without joints at the knees, but with a limited joint, that is, a small range of motion at the ankles. These springs were attached to a pelvic band. With these springs and a pair of axillary crutches the boy was soon walking about, and his appearance is shown in the accompanying photograph. He remained in the hospital until September 5, 1889, when an examination was made prior to his discharge. There was no appreciable increase in the power of the muscles

FIG. 1.



Representing the appearance of the boy when brought to the hospital.

were almost devoid of muscular power; what muscles remained were small and attenuated. There was slight power to move the toes of the left foot, but no such ability on the right side. The right thigh could be extended to an angle of 145° , the left to 135° . He presented a form of club-foot known as calcaneus. The internal condyles of both femoræ were quite prominent, and there was a marked

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FIG. 2.



Appearance of the boy as he left the hospital.

of the right lower extremity. He could move the left leg and also the foot, as well as the toes. The psoas and iliacus had evidently gained power. He has reported from time to time in the out-patient department; he attended school, and from a condition of helplessness he has become quite helpful to himself. Instead of walking like a kangaroo, he walks like a human being.

Examined September 2, 1891, he was found able to get about with the braces extending only above the knee, and with crutches. He goes to school. His

limbs are in very good position. The left thigh is extensible to an angle of 180° , the right to about 170° .

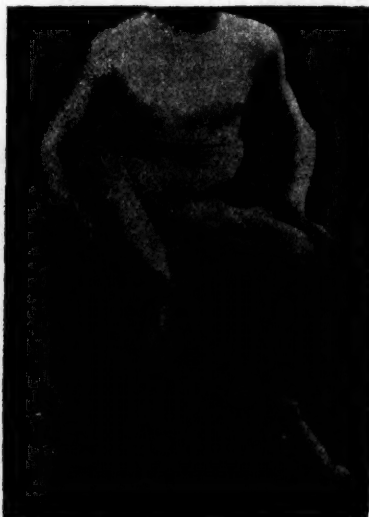
CASE IV.—A very helpless girl, cursed with an excess of adipose tissue, and only eight years of age, was admitted to the hospital January 27, 1890. Her poliomyelitis came on at two and a half years of age. This was followed by paralysis of the neck, and of the upper and lower extremities. She recovered the use of her neck and upper extremities, but her lower limbs remained more or less palsied, and the ligaments about the knee-joints became relaxed, so that when she came under hospital treatment she was very unwieldy, and was only able to balance herself on crutches. The thigh-flexors were shortened, the knees were in recurvatum and valgum, the right foot presented calcaneo-valgus, and the left foot varus. As she lay on the table for examination there was very marked lordosis of the spine—that is, when extension of the thighs was attempted. With the thighs flexed, however, this lordosis was overcome. The limit of extension of the left thigh was 140° . The right knee could be extended to an angle of 150° , the left was hyper-extended; there was very little power of flexion or of extension of the legs. There was a moderate amount of power in abduction, none in adduction, and no power of rotation. These movements pertained to the thighs. The legs and feet presented more or less paralysis in certain groups. The details are omitted as not pertinent to our subject. Suffice it to say that on February 4th she was subjected to about the same operation as in the preceding case. The left hip was found to be easily disarticulated, so that it was necessary to retain the dressings and plaster longer than is ordinarily done. By the first of April she was in a pair of long springs (without any joint at the knee) and on a pair of axillary crutches. She was discharged on the 12th of May. Recently she reported, to have her apparatus put in order, and she was found to be much more self-helpful. The mother states that the girl gets about comparatively well.

CASE V.—In March, 1889, a merchant of St. Louis brought his daughter, seven years of age, to New York in the hope of getting some relief from a paralytic deformity that made the child quite helpless. She had not stood alone or walked since she was fifteen months of age. At that time she had an attack of poliomyelitis. I found a great loss of power in the external rotators of the right limb; indeed, the paralysis was about complete. The internal rotators were also weak. The extensors of the leg were palsied, although the tensor vaginæ femoris and the sartorius seemed sufficiently strong to enable her to hold the limb extended for a minute or two. The flexors were weak, though not completely palsied. The extensors and flexors of the feet were palsied. By making a strong effort she could barely flex the toes. The flexors, especially the tensor vaginæ femoris, were shortened, so that it was impossible to extend the thighs beyond an angle of about 135° . In the left limb the gluteals were practically absent, the external rotators very feeble. The head of the femur rolled out of the acetabulum

with a thud; the flexors and adductors were especially strong and shortened, preventing extension beyond 135° . The extensors of the leg were palsied, the flexors good. The gastrocnemius was weak, but the girl could flex and extend the foot fairly well, although the limb was much atrophied. I advised an operation, and on the 24th of September, 1889, the shortened tissues were divided, the limbs brought down parallel with each other, and the deformity fully corrected. There was no reaction to speak of. Within a month she was fitted with apparatus and was soon in the upright posture, walking with the aid of crutches and splints. Soon after this she returned home and became quite active. I saw her on April 8, 1890, and made a careful observation of her condition. The thighs could be extended to fully 180° . The father gave me a report of her condition last November. She was still improving in the power of the ligaments.

CASE VI.—The most extraordinary case in the way of deformity was operated upon by me in

FIG. 3.



Appearance before coming under treatment.

October, 1890. It was that of a boy ten years of age, palsied when eighteen months old. The paralysis affected the muscles in the loin, right side, and both lower extremities. He had an enormous curve of the spinal column to the right. The right thigh was held flexed at an angle of nearly 90° , with the head of the bone resting on the dorsum ilii. The limb could be extended to an angle of 135° , though the muscles and tissues about the front of the hip were very short. The external hamstrings on this side were quite tense, not allowing extension of the leg beyond 130° . The tendo Achillis was short; the foot was in varus. On the left side the flexors of the thigh were shortened, but not to such an extent as those on the right side. The hamstrings were also shortened to a moderate degree; the tendo

Achillis was shortened. The thighs were much atrophied. (See Fig. 3.) I made an examination in my office and sent the boy to the hospital for operation. The impression made on my mind as he walked up the avenue on his crutches, with his right limb flexed, abducted, and rotated outward, was very painful. I wondered to myself if anything could be done to put that boy in better shape. By dividing the shortened tissues, pulling the limbs down into the best possible position, at the same time correcting the lateral curvature by manual force, I was enabled to hold him in plaster-of-Paris for several weeks. Then he was fitted with apparatus, put on crutches, and the result has been most gratifying. He walks erect, his limbs are parallel, he is growing, and his spinal deformity, which seemed to me almost hopeless, has improved at least 50 per cent.

I am aware that these case are incomplete from a strictly scientific point of view. I would hesitate to present them to a neurologist without a record of the electrical examination, the actual power (as measured by the dynamometer) remaining in the different groups of muscles, and also a record of these two points subsequent to the operation. Many years ago I reported my cases in this way, but of late years I confess that my examinations electrically have not been so precise. All I advocate is the correction of deformity, the removal of tension from a weakened muscle, the replacement of the joint-surfaces in normal apposition, and the assistance generally given to a limb the muscles of which are weak and palsied. In a number of cases I have been fortunate enough to secure the assistance of a neurologist, I first supplementing his work, he subsequently supplementing mine.

This crude paper is presented to the members of this Association merely as a contribution to the management of a very difficult class of cases—cases before which the neurologica heart often recoils.

THE PRE-TUBERCULOUS CONDITION.¹

BY J. HILGARD TYNDALE, M.D.,
OF NEW YORK.

CONSUMPTIVES may be divided into three classes:

1. Those with infiltration caused by mechanical pressure—the result of fixed pleuritic adhesions on the one hand, and on the other of connective-tissue proliferation and contraction in the lung itself—so-called chronic peribronchitis.
2. Those with infiltration as a remnant of acute disease, or with tuberculosis as yet strictly *localized*, the bacillus having forced an entrance into non-resisting cells.
3. Those with more or less rapidly diffusing

tuberculosis, *preceded* by a lowering of the general condition.

The first two start with *local* conditions at a time when there is a good, or a fair, general condition. The third class takes its starting-point from an *impaired general condition*, and it is of this I wish to speak.

I hold it as a maxim that *localized* tuberculosis does not of itself endanger life, so long as the general nutrition begets a *reasonable resisting power of the lung tissues*. Hence when the starting-point is an impoverished nutrition, we are dealing with the true pre-tuberculous condition.

My starting-point is, therefore, *general malaise*, as yet unaccompanied by any physical signs in the lungs, not even by modifications in rhythm or pitch of breathing. I will not dwell upon predisposition or acquisition any more than to say: Beginning with fetal life, colonization of the bacillus in early life is favored by:

1. Transmission with the ovum, kept in latent abeyance.

2. Inherent inability, in bodies built after the type of phthisical habitus, of the leucocytes to digest the bacillus tuberculosis.

Acquisition of the bacillus in later life is in the apparently healthy favored by:

1. Insufficiency in anatomical development of the thorax.

2. Insufficiency in physiological expansion, as *e.g.*, in the ossification of the cartilages. These two conditions of lessened mobility of the chest and a consequent stagnation of air, is shown in a tendency of the *upper* lobes to tubercular invasion.

3. Parts of lung being confined by pleuritic adhesions and thus affording facility for a prolonged lodgment of the bacilli—these receiving both board and lodging for a term sufficient for their development. This is especially true of the *lower* lobes.

From the above causal elements I now coin this general maxim: *Constructive or destructive metabolism is inherent in the person.*

Now as to the true pre-tuberculous condition, both in the constructives and the destructives, let me first clear my path of obstructions by excluding considerations of age, sex, or race; influences of previous general disease (typhoid fever); or of still present general trouble (syphilis, diabetes); also remnants of acute lung disease; suppurating wounds or other septic sources within the body; and cheesy glands in the neck or axilla,—as sources of *direct* infection. All these are centers of infection from demonstrable local sources.

Excluding thus all general and local disease enumerated above, we see our way clear to a conception of the true pre-tuberculous condition. We are consulted by a person that complains first and foremost

¹ Read before the American Climatological Association at Washington, D. C., September 25, 1891.

of *general malaise*. This general malaise is readily shown to be composed of partial failure of several or of all functions of the body; inability to exercise the motive power; muscular debility known as feeling "sawed-off in the legs;" sensation either more acute or dulled; sleep either fitful or too profound—always extremes; variable digestive capacity; superficial breathing; and last, but not least, a rapid heart-action. In other words, there is a falling off in the daily routine of eating, breathing, elasticity in walking, refreshing sleep, a buoyant mind, to which is added vague disturbances of sensation. As yet there is no elevation of temperature. This is the rough picture of the *general* condition—by inclusion, if I may so call it. By exclusion, you will now find *acute* diseases (typhoid fever, for example) absent; likewise *chronic* ones—of which diabetes may serve as an example.

Approaching the local condition we find that, as yet, inspection, auscultation, and percussion furnish no clue whatever, not only as to dry and moist râles, but even as to changes in the respiratory elements of quality, pitch, or even of rhythm. This leads us to our second maxim: All more than temporary departures from well-being, of which the patient has been conscious for weeks or perhaps even months, and which by careful diagnosis cannot be made to fit into the frame of a recognized trouble, acute or chronic, functional or organic, represent the true pre-tuberculous condition. Correct appreciation of the pre-tuberculous condition can only be reached by exclusion.

Nothing now remains except to sharply outline the exact sequence of events in the pre-tuberculous condition, and in order to make the picture as clear and as distinct as possible, I shall divide the events into stations. Please bear in mind that I aim to give, in a few words, the whole course of the pre-tuberculous disease from beginning to end, and desire this to be remembered: The first station is entirely made up of *subjective* symptoms, and represents the true pre-tuberculous condition. The second and third stations are made up of the same subjective malaise, *plus* the objective findings in the lungs—and these merge into well-known types of tuberculous invasion.

Station First (*subjective*). General malaise, not fitting into the frame of recognized acute or chronic disease—in this respect comparable to neurasthenia, which is also diagnosed by exclusion. As stated above, "general malaise" is a falling off from the individual norm of eating, breathing, muscular power, refreshing sleep, buoyant mind, etc. This impaired *general* condition leads up to the *local* lesion, both subsequently uniting to bring about destruction.

Station Second. This consists in the above subjective symptoms *plus* the objective change in the

character of the respiratory elements, but as yet without râles, either dry or moist. The general condition advances to noticeable loss of adipose tissue in some, or, in others, of red blood-corpuscles, up to the verge of pernicious anemia—or to both combined. The order of importance in respiratory changes is, in auscultation: quality, pitch, and rhythm. The changes now occurring are in the reverse order of their importance: rhythm first, then pitch, then quality. This is the main point I wish to emphasize. As to *rhythm*: Interrupted (cog-wheel) inspiration (a pause not existing in the norm), a prolonged and audible expiration. As to *pitch*: Higher than the original vesicular low pitch. This holds good of both auscultation and percussion, and is in accord with Dr. Leaming's great law: Low pitch denotes porosity, high pitch denotes density. As to *quality*: From vesicular to broncho-vesicular, and finally bronchial, or, as I prefer to call it, tubular.

Station Third. Dry, followed by moist râles and gurgles, according as the tuberculous invasion begets a localized or a widespread bronchiolitis or local excavation. The third station of pre-tuberculous patients is, therefore, either a direct rush into diffused tuberculosis (general bronchiolitis, or tuberculous pleurisy) in those of destructive metabolism; or, in those of constructive metabolism, a more gradual destruction by infiltration and excavation, perhaps with subsequent limitation.

In conclusion, I offer the following maxim: The pre-tuberculous condition is a tuberculous invasion as yet undemonstrable, engrafted upon those whose nutritive changes have brought them to a condition below par as compared with their usual physiological condition. This physiological unit is strictly and absolutely individual.

INHERITED SYPHILIS OF THE LARYNX.

BY S. G. DABNEY, M.D.,

CLINICAL LECTURER ON DISEASES OF THE EYE, EAR, AND THROAT, AT THE HOSPITAL OF THE COLLEGE OF MEDICINE; VISITING SURGEON TO EYE, EAR, AND THROAT DEPARTMENT, LOUISVILLE CITY HOSPITAL, LOUISVILLE, KY.

THOUGH much has been written on the subject of laryngeal disease due to acquired syphilis, we find in the text-books but little descriptive of the inherited form of syphilis manifesting itself in the larynx. Thus Mackenzie says: "Hereditary syphilis (of the larynx) is occasionally met with in children, though I have never seen a case in a child younger than seven years. In each of the five examples I have met with there was ulceration of the edge of the epiglottis, with exposure of the cartilage." Lennox Browne is of the opinion that "as a rule the ulceration of congenital syphilis is limited to the palato-pharyngeal and naso-pharyngeal tissues,

and that laryngeal mischief is a comparatively rare sequel." The following cases, therefore, seem worthy of report as illustrating hereditary syphilis of the larynx, and perhaps as possessing some points of interest in themselves:

CASE I.—Miss B., aged sixteen, consulted me in November, 1890. The medical history given by her mother was as follows: The patient was the oldest of five children, all of whom had been fairly healthy. In November, 1889, she had diphtheria, several other children in the neighborhood being affected at the same time. For this she was attended by my friend Dr. A., who corroborates this part of her story. After recovery her throat remained weak, and in the spring of 1890 it gradually became much worse. From that time until her visit to me her symptoms had gradually increased in intensity, although she had during this time been treated by three physicians.

On examination I found the patient to be marked by the doughy skin, facial cicatrices, and peg-shaped, notched, upper incisor teeth, described by Jonathan Hutchinson. Her voice was so rough and hoarse and low, that it was difficult to understand what she said. She suffered no pain, but had great discomfort in swallowing, and even in speaking. Her mother said that her breathing when asleep was noisy and difficult. Examination of the nose showed only some hypertrophy over the turbinated bones. The uvula was long and club-shaped, and quite deeply ulcerated on its lower posterior surface. The laryngoscope showed the epiglottis to be eaten away in perhaps one-fourth of its extent, the ulceration having proceeded from the edge. What remained was much thickened and of nodular surface, somewhat resembling lupus. The ary-epiglottic folds were also thickened, and on and above the ventricular band of each side was deep ulceration. It was impossible at this time to see the cords.

The diagnosis lay between tuberculosis and syphilis, acquired or inherited. Careful examination gave no evidence in favor of phthisis, and absolutely no history in any way suggestive of acquired syphilis could be obtained. The age and social standing of the patient, and the character of the lesions, which could only be tertiary if acquired syphilis produced them, made this supposition altogether unlikely, though of course not impossible. I was thus led to regard the case as one of inherited syphilis attacking that part whose power of resistance had been lately lessened by diphtheria. This tendency of hereditary disease to invade a weakened organ is well known.

Dr. Adolf Bronner, at a meeting of the British Ophthalmological Society, lately called attention to the appearance of congenital syphilis in injured eyes. In the case just related rapid improvement took place under the daily administration of sixty grains of iodide of potash and one-sixth grain bichloride of mercury, together with the use of detergent sprays and nitrate of silver locally.

CASE II.—Miss B., aged seventeen. Her father and mother died when she was five years old. Their medical history is unknown. She has one brother, two years her senior, and reported healthy. Miss B. became almost absolutely deaf at fourteen years of age, the deafness being permanent, unattended by pain, and attaining its maximum in about three months. At the same time she suffered from diffuse inflammation of each cornea, whose traces as well-marked opacities are still visible. She came to see me on account of her throat. I found a long perforation in the anterior faucial pillar of the right side, deep and ragged ulceration of the pharynx, and one large irregular ulcer on the right ventricular band of the larynx. Here the diagnosis was unmistakable. Appropriate treatment was followed by speedy improvement.

CLINICAL MEMORANDA.

CASE OF COMPARATIVELY LATENT AND QUICKLY ENDING DIABETES AFTER INFLUENZA.

BY M. MAGELSON, A.M., M.D.,
OF FERGUS FALLS, MINN.

MR. K. F. L., a farmer, thirty-three years old, sought my advice on the 26th of June, saying that he had previously enjoyed good health; until the beginning of last April he had pains in the back of his head, with sneezing, soreness of the eyes, lancinating pains in the arms and legs, fever and a feeling of general weakness. In fourteen days this attack left him, and he was then very weak, had considerable cough, lost his appetite and ran down in flesh. He spat some blood one week in May, and sought medical advice on account of his lungs. He grew weaker, the cough got more and more annoying, and he raised more and more of a thick greenish expectoration. In the middle of May he had some night-sweats. Examination showed a chronic bronchitis in both lungs. He complained of weakness, loss of appetite and a steady cough that disturbed his sleep. His tongue was markedly dry, and this, as well as the upper part of his throat, had a glazed appearance. He was not very thirsty, and did not pass his water frequently, and it is especially to be noted that he did not have to pass it in the night. There were no symptoms of itching or impairment of sight, no odor from his skin or breath, and no sweating. His bowels moved regularly every day. His urine was clear in color, reddish yellow, and had a specific gravity of 1042. The amount passed in twenty-four hours was 1760 c.c. By approximate valuation of the amount of Fehling's test solution, the percentage of sugar was estimated as between 20 and 25 per cent. As the amount seemed to me to be extraordinary, two drops of the urine were evaporated at common summer temperature upon an ordinary glass slide, and photographs made of the sugar deposit in each drop magnified 22.5 diameters. I will remark that the height of the deposit was fully proportioned to the extension. He stayed a week under a treatment of opium and Carlsbad Sprudelwasser. The cough stopped and he slept well, but there was no lessening of the amount of sugar in the urine. On the 30th of June he went home to Dakota, about seventy miles

from me, as I had told him that I thought his disease was incurable. On the 3d of July he died. From the description that his wife gave me in a letter, I think he died in diabetic coma. The case is interesting from the facts of its short duration, its comparative want of symptoms, and as a direct result of a rather moderate attack of influenza. Because I did not have sufficient time to make exact and repeated quantitative analysis of the amount of sugar, I will not discuss the amount but only say that I was convinced that it was surely 25 per cent.—larger, indeed, than in that of any other case that I have seen reported.

STEEL IN THE IRIS FOR TWENTY-SEVEN YEARS.

BY F. C. HEATH, A.M., M.D.,

OCULIST TO ST. ELIZABETH'S HOSPITAL, LAFAYETTE, IND.

SOME time in 1864, Mr. P. E. H. was engaged in reaming a tire on a locomotive engine, when a small piece of steel, about two mm. long, from the reamer, penetrated the cornea of his right eye, lodging in the iris, about midway between the pupil and the outer margin. In about four weeks the "irritation" fully subsided. It gave no further trouble until five years ago, when inflammation arose, as he thought, from irritation of the eye by gravel. This quieted down after a week's treatment by Dr. J. L. Thompson, of Indianapolis.

The patient came to me in June last with a well-marked iritis that had started five days before. He again made a good recovery, under two weeks' treatment with atropine, leeching, etc., and the eye has been free from pain, ciliary injection, or other symptoms of iritis ever since. The vision is unaffected.

It is exceptional for a foreign body to remain so long in the iris and produce so little trouble. Noyes mentions a similar case of *nineteen* years' duration, but this is *twenty-seven*.

BLACK STAINING OF DIAPERS FROM THE USE OF SALOL.

BY S. RUSH KETCHAM, M.D.,

OF PHILADELPHIA.

It has been my custom to use salol considerably in diarrheal diseases of children, and in the case of a child six months of age I used two-grain doses three times daily. In about forty-eight hours the mother was greatly excited, and told me her child was passing blood in the urine. I immediately called for the diapers, and finding numerous stains of a dark-pink and black color, I concluded that they positively were not blood-stains, but that they were produced by carbolic acid, as salol is chemically a salicylate of phenol. No other symptoms were present, and, after ceasing its administration, the staining of the diapers disappeared in twenty-four hours.

MEDICAL PROGRESS.

Esophagotomy.—KRÖNLEIN (*Corresp.-bl. für Schweizer Aerzte*, August 15, 1891) presented to the Society of Physicians of Zurich the case of a man, fifty years old, who swallowed a bone, which became impacted in the esophagus. Subsequently the stools were bloody

and the man became anemic. Attempts to remove the obstruction failed. Twelve days after the accident, esophagotomy was performed. The only complication encountered was hemorrhage from the eroded superior thyroid artery, which was readily controlled. The sharp-cornered foreign body was removed. The wound of the operation healed satisfactorily, but exhausting hemorrhages took place. Nevertheless, complete recovery ensued in the course of six weeks, the patient, however, being still anemic. Krönlein took occasion to state that he had already performed esophagotomy for foreign bodies in four cases.

Traumatic Communication of Carotid Artery and Cavernous Sinus.

—WHERRY (*Lancet*, August 29, 1891) reports the case of a lad, thirteen years old, who, after a traumatism, presented the symptoms of concussion of the brain. Double ptosis, with dilatation of the pupils, developed. Three weeks after the injury, the boy was seized with tetanic spasm of the head and neck. On the day following, the eyelids were edematous, with proptosis of the left eye. Under energetic treatment some improvement took place. At the end of another three weeks there occurred an attack of severe pain in the left orbit, with increased proptosis. An incision disclosed an extravasation of blood in the cellular tissue of the left upper lid, with distinct pulsation. On auscultation of the forehead, a loud bruit was detected. The sound was continuous, but was reinforced with the pulse, and could be obliterated by compression of the left carotid artery. On ophthalmoscopic examination, evidences of double optic neuritis were found. It was held that the base of the skull had been fractured and a communication established between the carotid artery and the cavernous sinus. A certain degree of improvement took place, but ultimately it was determined to ligate the left common carotid artery. This was accordingly done. The bruit at once ceased, but alarming symptoms developed. For a month there was coma, with dysphagia, incontinence of urine and feces, paralysis and rigidity, but recovery ultimately took place.

Gumma of the Retina.—LEWIN (*Berl. klin. Wochenschrift*, July 13, 1891) presented to the Dermatological Society of Berlin the case of a man twenty-six years old, in which, thirty days following infection and two weeks after the development of a chancre, an echthymatous eruption, drying into black crusts, appeared all over the body and face. At the same time retinitis pigmentosa was detected, as well as a bean-sized prominence in the lower left quadrant of the retina, which it was concluded was a gumma. Obstinate at first, the condition gradually yielded to subcutaneous injections of iodide of mercury.

Treatment of Hyperidrosis.—In the *Revue Générale de Clinique et de Thérapeutique*, the following prescription for sweating of the hands and feet is given. The application is to be made night and morning. The part is first washed with hot water and immediately afterward the following ointment is applied:

R.—Ichthyol 1 ounce.
Vaselin 1½ ounces.

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SATURDAY, OCTOBER 10, 1891.

THE THERAPEUTIC VALUE OF HYPNOTISM.

SEVERAL important books upon Hypnotism have appeared during the current year in France and Germany, and the question of its therapeutic value cannot be considered as settled. All, however, agree that the method has great dangers if its unrestricted practice be allowed, and that the eye of the law must be kept sharply on the watch to guard against easy abuse and invited danger. PREYER's book (*Der Hypnotismus*, etc.) of 217 pages accepts almost none of the modern additions and claims; it rests essentially upon the development of the "science" as given by the older masters, BRAID, HEIDENHEIM, CHARCOT, etc. BERNHEIM's 500-page octavo (*Hypnotisme, Suggestion, Psycho-thérapie: études nouvelles*) is the completest and latest exposition of the leader of the Nancy school. The volume is largely devoted to the clinical histories of cases in which, according to the author, hypnotic suggestion has been able to effect cures in a multitude of cases of multiform nervous disease. WETTERSTRAND of Stockholm (*Der Hypnotismus und seine Anwendung in der praktischen Medicin*, 122 pages), is also an enthusiastic believer in the power of suggestion to cure disease. He has had an immense clinical experience—over 3000 cases. He describes

in detail and with perfect sincerity the histories of cures of rheumatic disease, epilepsy, morphinomania, and many other types. RINGIER's volume of 200 pages has a double interest, in that the author is a country practitioner and that he is a conscientious and earnest character, carefully trying to get at the truth of the value of suggestion-therapeutics. He subjects his 210 cases to careful scrutiny and gives as close an analysis of his failures as of his successes. He divides his cases into seven groups: 1. Those neuroses pertaining to the motor, vasomotor, or secretory systems; 2. Neuroses of the emotions, or neuralgias; 3. Insomnia; 4. General cerebral neuroses or psychoses; 5. Rheumatic affections; 6. Intoxications; 7. Sundry affections. LIEBEAULT's *Thérapeutique Suggestive* (300 pages) will have especial interest for students of animal magnetism. He frankly confesses that his former experiments of this kind upon children have proved mere illustrations of suggestion-hypnotism. There is also a free confession of many injuries to patients committed by him in hypnotic experiments.

Those interested in the question of the influence of drugs upon the suggestibility of the patient, especially its increase by cannabis, may consult SCHRENK-NOTZING's *Die Bedeutung narcotischer Mitteln für den Hypnotismus*. The psychological aspects of hypnotism are especially treated in JANET's *l'Automatisme psychologique* and DESOIR's *Experiment. Pathopsychologie* (*Vierteljahrsschrift für wissenschaft. Philos.*, Jan. 15, 1891).

A thoughtful and conservative practitioner, DR. ESKRIDGE, delivered an excellent address upon this subject before the Colorado State Medical Society, which is published in the *New York Medical Journal*, August 1, 1891. The whole subject is reviewed in the light of a not inconsiderable personal experience. The value of hypnotism as a therapeutic agent is found to depend upon mental impression and the permanency of the same. No mysterious influence other than this is exerted over the subject, and the state of hypnosis, so far as the physician is concerned, is simply a condition of greater sensibility to impressions. Indeed, repeated impression without the abnormal suggestibility of hypnosis is often quite as effective. DR. ESKRIDGE rightly emphasizes the dangers of hypnotic practice in the hands of the ignorant or incompetent, and strongly urges the legal restriction of licenses to physicians and scientific investigators.

It remains an open question whether the unre-

ventable dangers of hypnotic practice will be found to outweigh the therapeutic use and value. The domination of a weak will by a strong one, the control of attention either by another's or by one's own will, the direction of emotion by effort and resolve—these are the commonest facts of every-day life. It would seem that much of the philosophy and mystery of hypnotism come down to this simple explanation: viz., that it consists in renunciation of self-control and in heightening and emphasizing the power of the attention, and in fixing the will-less mind in determinative control of in-coming sensation and out-going innervation. When the attention is absorbed by one thought or act or sensation, others that come to the consciousness are unnoticed. Again, when the will is absorbed in one act, another may be carried out without consciousness. These are normal, every-day facts; hypnosis simply morbidizes the condition. It is usually only diseased and weathercock wills that the breezes of external suggestion can blow hither and thither, and though such wills are sad enough and common enough facts, the ideal of true character must consist in self-control and autocracy. Consequently the physician that uses hypnotic suggestion or plain common-sense advice and encouragement, must do it with the distinct object of righting the diseased will and strengthening it in self-control. It can hardly be doubted that the hypnotizing therapists have often been more occupied with the psychology than with the cure, and that the education of the patient's self-control has not always been a primary object. Hysterical condition has been produced in order to cure hysteria, and neurosis *b* has replaced neurosis *a*. If human vivisection, practised with the clearest and most earnest desire to thereby further human weal, is squarely criminal, it may be conceded that to play and juggle with the profoundest mysteries of neurological and psychic life is the most wanton cruelty. About the inter-relations of will and sensation, mind and body, consciousness and nerve-centers, we know quite as much as a Hottentot savage would know about the use of the instruments at the Lick Observatory. The tricks of the hypnotist with the enslaved consciousness remind one of what the savage might do among the telescopes. We must have a better psychology and an infinitely more perfect pathology and pathogeny of psychic disease, before we shall be capable of intelligent use of hypnotic control and suggestion as justifiable methods of cure. Let us make haste very, very slowly.

EMPLOYMENT OF INSANE IN THE EASTERN MICHIGAN ASYLUM AT PONTIAC.

It gives us pleasure to excerpt the following from the biennial report of the Medical Superintendent of this institution:

"The policy long ago inaugurated and carried into execution in respect to employment of patients has been continued and extended on certain lines. In addition to the employment of male patients in the care of stock, upon the farm, in the shops, and in working-parties of the more trustworthy, under the direction of an out-door attendant, the plan has been adopted of sending out, in rotation, parties from each of the 'disturbed' halls in the male department, once a week in the summer season, to do odd tasks of weeding, raking, grading, wheeling cinders, road-making, and similar light work. This exercise has taken the place of the purposeless walk, and has been found to operate favorably in promoting the quiet and comfort of the halls and the welfare of patients as well as beautifying and adorning the Asylum premises. Under this system it is practicable to give employment to nearly all male patients who are physically able to undertake work out of doors. The enlargement of the kitchen has afforded additional room for the employment of patients in this department, and the increased numbers under treatment have rendered it necessary that this help should be supplied to the kitchen. For female patients an ironing-room has been fitted up at the laundry, and parties from the different halls assist regularly in ironing. The substitution of gas heaters for the large stove formerly in use for heating flats, has economized the time of employes and patients, and has rendered the accomplishment of laundry work less difficult. It has been found practicable also to employ in connection with the wash-room in the laundry several female patients of vigorous constitution.

"These additional opportunities for employing patients have been of the utmost value in treatment, and their importance cannot well be over-estimated. It is contemplated during the coming biennial period to introduce broom- and brush-making, and thereby furnish in-door employment to certain male patients in unpleasant weather.

"On the day that this is written, there are actually employed out of doors and in different outside departments of the Institution 248, out of a total of 518, male patients, and this is in addition to those regularly employed in in-door occupations and hall work."

AN ERA OF PREVENTIVE MEDICINE.

THE world is progressing. It is not sufficient to be provided with remedies for correcting existing

evils; the demand of the hour is for means that will prevent their occurrence. As our knowledge of disease grows, not only are we better fortified to combat it, but we are also placed in a position in which we can obviate its development or extension. It is especially the etiology of disease from which we can hope to learn the prophylaxis. An era of preventive medicine has set in—not with any abruptness, it is true, for the prophylaxis of disease is as old as medical practice itself, of which it forms but a part; but the subjects of hygiene and sanitation and vital statistics have become matters of popular education.

As we learn more of disease, and as the superstitions surrounding it and its therapeutics are dispelled, the conviction becomes stronger that with some notable exceptions we can do little to overcome the disease-process. The most we can hope for is to assist and encourage Nature in her efforts to bring about recovery, removing complications and meeting emergencies as they arise. It thus becomes quite as important to know when to abstain as when to interfere.

What has been said in the foregoing is borne out by the proceedings of the Seventh International Congress of Hygiene and Demography recently held at London. The meeting occupied an entire week, was patronized by the highest authorities of England, and was participated in by some of the most brilliant minds, both lay and medical, of many countries. A glance at the work of the Congress, but a brief summary of which we have been able to present, will show how far-reaching were the subjects discussed, of which a pleasing feature is that they deal not only with disease and causes of disease, but with the relations of these and of environment and occupation to individuals and to communities. They enter into the very lives of the people. The hope is justified that much good may result from the deliberations of a body so strong, both intellectually and politically, as was this last Congress. While there may be a want of unanimity of opinion as to the immediate causes of disease, there is less diversity as to the general measures to be adopted to prevent its spread.

THE QUACK AND THE POSTMASTER.

WE have received copies of circulars presumably sent to all the postmasters of this country, in which extraordinary inducements are offered them in order to secure, by their aid, lists of persons that receive

their mail at a specified office. The lists are to be of two kinds: all those not invalids, and those that are suffering from any chronic ailment. The postmaster is especially instructed to give "the names of persons suffering from rupture (breach), for which we possess a new and radical means of cure; also, those suffering from piles, or from fistula-in-ano, for both of which diseases we have new, improved, and radical methods of treatment, or of those afflicted with diseases of the throat and chest; or of the digestive organs, heart diseases, diseases peculiar to women, scrofulous diseases, as fever-sores, white swellings, and old sores or ulcers; also, the names of any sufferers from diseases of the urinary organs, as diabetes, Bright's disease, gravel, inflammation of the bladder, stone in the bladder, strictures, and kindred affections; or from epilepsy, or fits, chorea or St. Vitus's dance, paralysis, curvature of the spine, nervous debility, or from tumors, or any other chronic diseases, for all of which our Institution offers special advantages and facilities for treatment. Please to be particular to indicate opposite every name, 'in the Invalids' division of the list,' the disease (if known to you) with which the party [*sic*!] is supposed to be afflicted."

Upon the receipt of the list the presumption is that the people will be deluged with testimonials and promises to cure, from the proprietors of the "Cosmic Dispensary and World's Therapeutic Institute."

The only law or ruling pertaining to this abuse of the United States Postoffice for the purpose of preying upon the gullible, is contained in the following Postoffice order: "Complaints having been made to this Department that the names of persons within the delivery of postoffices are frequently furnished by postmasters upon the application of parties desiring to mail to the addresses so furnished improper matter, covering, in many cases, indelicate advertisements or cunningly devised schemes to defraud, postmasters are hereby forbidden, in any case, to furnish such lists, until they are satisfied the parties making the application will not use the names for improper purposes, and reasonable assurance has been given that such lists will not be offered for sale or transfer."

It would appear that this lax instruction is not by any means sufficiently explicit and inhibitory. The execrable business should not be thus even indirectly aided by the General Government. The physicians of each village and town should see that the postmaster does not thus disgrace his office.

EDITORIAL INDEPENDENCE.

WE trust that no reader of THE NEWS will fail to reflect upon the striking condition of medical journalism, at least in one instance, illustrated by the incident related in DR. DILLER's letter, published in another column of the current issue of THE NEWS. It remains wholly within the power of the conscientious physicians of this country to determine whether their professional journals shall be solely devoted to unbiased medical truth and science, or whether these journals shall be the hypocritical mouthpieces of concealed control or of financial scheming. What a shame that the editor in question did not at once resign rather than write that second letter!

SOCIETY PROCEEDINGS.**AMERICAN NEUROLOGICAL ASSOCIATION.**

Seventeenth Annual Meeting, held at Washington, September 22, 23, and 24, 1891.

FIRST DAY—SEPTEMBER 22D.

DR. WHARTON SINKLER, of Philadelphia, delivered the President's Address. He recommended that an effort be made each year to obtain papers from some of the foreign honorary and associate members. He announced that since the preceding annual meeting twelve books and one hundred and seventy-seven papers had been published by Fellows of the Association.

Dr. Sinkler reported "A Case of Acute Spinal Paralysis; Death on the Twelfth Day; Autopsy Showing Transverse Cervical Myelitis, with a Report of the Microscopical Examination by Dr. C. W. Burr." The full text of the paper is to appear in a subsequent number of THE MEDICAL NEWS.

DR. W. C. KRAUSS, of Buffalo, read a paper on "Poliomyelitis Acuta Adultorum," in which he reported a case in a man, forty-three years of age, previously strong and healthy and with a good antecedent history. Two of the grandparents had severe attacks of measles between thirty-five and forty years of age. The father also had a severe attack of measles at thirty-four. Some members of the family displayed evidences of insanity. The patient had a severe attack of measles when thirty-eight, from which he failed to recover perfectly. At forty he was seized with fever and pain in the neck, extending down the spine. Subsequently paralysis of the trunk and extremities developed, without apparent sensory disturbance. Some improvement took place in the course of the subsequent three or four weeks. Nine months after the onset of the attack, however, the four extremities were still palsied, with atrophy, cyanosis, and edema, and with loss of faradic irritability. The reflexes were wanting; some power in the back had been regained. Dr. Krauss was unwilling to admit that the attack of measles was sufficient to precipitate a profound spinal lesion, but believed that when a neuro-

pathic or psychopathic heredity existed, any infectious disease may induce derangement of the nervous system. In the case reported, little or no improvement followed the subsidence of the general symptoms.

DR. CHARLES K. MILLS, of Philadelphia, stated that the association of poliomyelitis and multiple neuritis is comparatively common. He related a case occurring in a child, seven years of age, in which an attack of diphtheria was followed by peripheral pains and paralysis of a group of muscles in one leg. The question of infectious diseases causing multiple neuritis in association with poliomyelitis is an interesting one. Such a result is more likely to be brought about by various toxic agents. In one case under the observation of Dr. Mills the paralysis was general, but recovery took place. There was probably an association of both lesions. Years ago Dr. Mills had directed attention to this concurrence, particularly in arsenical poisoning.

DR. ROBERT T. EDES, of Washington, thought that this concurrence might also result from the action of alcohol.

DR. G. L. WALTON, of Boston, referred to a case of multiple neuritis dependent upon lead-poisoning, with atrophy, ataxia, etc., in which death took place after spinal symptoms and cystitis. Owing to their coexistence, absolute differentiation of spinal and peripheral lesions is sometimes unnecessary.

DR. C. L. DANA, of New York, stated that in all cases of acute or subacute neuritis from alcohol, rheumatism, etc., the lesion is confined almost exclusively to the peripheral nerves. He has numerous specimens to substantiate this view, in connection with the clinical histories. The condition in chronic neuritis is not so certain.

DR. G. L. WALTON, of Boston, reported "A Typical Case of Thomsen's Disease." W. C., twenty-nine years old, a printer, had suffered since boyhood from difficulty in using his muscles after a period of rest. As a child he was clumsy, and often stumbled. The trouble reached its maximum at fifteen, and has since remained stationary. Practically, all the muscles are affected, including those of the eyelids and of deglutition. The patient starts with a slow, waddling gait, but soon walks rapidly and without fatigue. Strength is preserved and the muscles are very large (according to a photograph shown). A moderate faradic current develops tonus. No other member of the family is affected in this way, but the father is said, during early manhood, to have presented a mild degree of a similar disorder. The differential features between this affection and the congenital paramyotonia of Eulenburg were shown by a case of the latter affection in a man of sixty-seven years, characterized by tonic spasm and weakness, lasting for from fifteen to thirty minutes, brought on by exercise and disappearing after several recurrences, when the exercise was continued. The affection had been observed from infancy. A brother and daughter of the patient suffered from the same disorder.

The two diseases are analogous, each depending upon a congenital defect in the muscular apparatus, perhaps also in the central nervous system, the difference consisting in the mode of onset of the increased muscular irritability.

DR. C. H. HUGHES, of St. Louis, maintained that

Thomsen's disease is an affection of the muscular system, and doubted the entity of the disorder, considering it symptomatic.

DR. PHILIP COOMBS KNAPP, of Boston, read a paper on "Astasia-Abasia," which he defined, after Blocq, as a morbid state in which the impossibility of standing erect and walking normally is in contrast with the integrity of sensibility, of the muscular strength, and of the coordination of the other movements of the lower extremities. Dr. Knapp had collected forty-nine cases from various sources, and reported a case under his own observation. The patient was a male, fifty-eight years of age. When recumbent, movements were fairly vigorous. Sudden spasm, with rigidity of the extremities, occurred. Subsequently retropulsion, difficulty in articulation, and involuntary movements developed. Tonic treatment was inefficacious. The best results have been obtained by moral treatment and the substitution of volitional for automatic movements. The condition cannot be considered a morbid entity, but a complex of symptoms.

DR. G. M. HAMMOND, of New York, maintained that the affection is not organic, because the movements of walking could be performed when the patient was recumbent. He considers the affection a manifestation of hysteria. He had found bicycle-riding a most useful remedy.

DR. C. L. DANA, of New York, corroborated Dr. Knapp's suspicion of the case as one of paralysis agitans. He had a patient presenting astasia-abasia, with manifest paralysis agitans.

SECOND DAY—SEPTEMBER 23D.

DR. MORTON PRINCE, of Boston, read a paper on "The Pathology of Hysterical Anesthesia," illustrated by two cases showing some unusual phenomena. In the cases demonstrated, notwithstanding the existence of deep anesthesia, impressions upon the hand were felt. Pinching and pricking were not recognized. When the subjects were hypnotized, they accurately described the tests that had been applied to the anesthetic parts, of which they had not been conscious. The impression was thus felt, but not perceived. The most probable explanation is that the middle sensory centers of Hughlings Jackson were normal, but that the highest centers, in which impressions are coordinated with the other psychic states constituting consciousness, were inhibited.

A paper on "A Case of Tumor of the Cerebellum, in which Trephining was Done for the Relief of Pressure," by DR. PHILIP COOMBS KNAPP and DR. E. H. BRADFORD, of Boston, was read. The report was of a man, twenty-eight years old, with a negative family history, who had poliomyelitis when seven months old. When twenty-six, severe right occipital headache developed, with diplopia, impairment of vision, double optic neuritis, convulsive attacks and nausea and vomiting. Ultimately vision was entirely lost, as well as the sense of smell. Large doses of iodides accomplished no improvement. Hearing was lost; difficulty in deglutition and in articulation developed. The mental condition remained unaltered. A trephining operation in the right temporal region over the Sylvian fissure was followed by relief of the pain. Hernia cerebri developed and death took place two months after the operation.

At the autopsy a tuberculoma was found in the left lobe of the cerebellum.

A paper, entitled "A Case of Trephining and Excision of the Cortex for Jacksonian Epilepsy," by DR. W. W. KEEN and DR. CHARLES K. MILLS, of Philadelphia, was next read. The case reported occurred in an adult who, ten years previously, presented left hemi-paresthesia, to which, five years later, left hemi-spasm, without loss of consciousness, was added.

Dr. Keen trephined over the motor cortex and removed the centers for the shoulder and the upper arm. There were found thickening and sclerosis of the bone and a small growth over the dura, which, upon microscopical examination, proved to be a sarcoma. Three days after the operation, there was paralysis of the arm and leg, but by the thirtieth day power had completely returned. No sensory symptoms developed. During eight weeks after the operation convulsions occurred, but they were of milder character than they had been. Eventually further improvement took place.

A paper on "Porencephalus, in which Trephining was Done for the Relief of Local Symptoms; Death from Scarlet Fever; Exhibition of the Specimens," by DR. DE FOREST WILLARD and DR. J. HENDRIE LLOYD, of Philadelphia, was read, in which was reported the case of a child, seven years old, with cerebral spastic hemiplegia. There were inability to walk and internal strabismus. The child was well developed. Sensation was unimpaired. There were convulsions, followed by enfeeblement of the mental faculties and athetoid movements of the right arm. As the child was rapidly growing worse, trephining was performed. Three days after the operation scarlatina developed and the child died on the eighteenth day. The autopsy disclosed no evidences of meningitis, but a condition of porencephalus involving the Rolandic region.

DR. C. L. DANA, of New York, admitted the validity and utility of operation in certain cases. He maintained conservative views as to the propriety of operating in cases of Jacksonian epilepsy, tumors, for the relief of pain, and in porencephalus, and was desirous of hearing opinions as to the details of excision of the cortex and as to operation for infantile cerebral hemiplegia. Such cases are often associated with epilepsy, imbecility or idiocy. Dr. Dana had obtained the histories and the specimens in twelve cases of cerebral tumor that were not operated upon. Three could have been recognized, localized and operated upon. In two others, sarcomata occupied the middle of the central convolutions.

DR. B. SACHS, of New York, stated that the result of surgical interference in focal epilepsy was particularly distressing. It had been shown that after removal of the focus the secondary degeneration also involved the cortex. In cases of tumor, operation promises the more favorably as secondary degeneration is the less thoroughly established. In focal epilepsy, improvement may be secured, but not cure. Dr. Sachs believed that in no case has there been freedom from attacks for two years after the operation. It would seem that operations upon cases of porencephalus would but tend to increase the size of the existing cavity. Cases should be carefully selected or the operation would fall into discredit. In porencephalus the motor symptoms are decided, while the mental symptoms are slight. The

evidence points to a pre-natal condition rather than to an acquired cerebral palsy. Cases of the latter kind are suitable for operation if seen at an early stage. Such a condition is frequently due to meningeal hemorrhage, and operation should be performed early. If secondary degeneration has taken place, the operation will prove useless.

DR. C. B. NANCREDE, of Ann Arbor, related a case in which no spasm had occurred for three years after operation. In focal epilepsy of long standing, he believed that hernia cerebri occurred as a result of encephalitis.

DR. BREMER, of St. Louis, called attention to the importance of testing the muscular irritability by applying the faradic current to the shaved scalp. He had found the irritability greater on the affected side. He reported a case of successful operation for focal epilepsy, with the results of an examination of the portions of the cortex excised. There were no changes in the cellular elements, but there was profound hemorrhage into the intravascular spaces. This admonishes the avoidance of too much pressure on the cortex during operation.

DR. E. P. DAVIS, of Philadelphia, expressed the view that meningeal hemorrhage in the newborn is generally due to disease of the mother, such as chronic nephritis; in this way a tendency to vascular degeneration is transmitted to the infant, with a predisposition to hemorrhage. He believed in the propriety of early surgical interference only in marked cases. The results are unsatisfactory if the mother has suffered from constitutional disease.

DR. BULLARD, of Boston, reported a case in an adult with hemiplegia and epilepsy, in which trephining was performed and the hemiplegic cyst evacuated. No attacks occurred in the subsequent two months.

DR. J. J. PUTNAM, of Boston, stated that one may be deceived in concluding that there must be focal disease because there are local spasms. Even diffuse lesions may give rise to focal symptoms. This fact explains some of the unsuccessful results of excision.

In closing the discussion, DR. KEEN said he was not aware of the character of the tumor at the time of operation. It is possible that its removal, without excision of the cortex, would have been the better operation. In no case had he observed a positive or permanent cure. The operation was warranted by the probability of the relief it was expected to afford. He had in this case on microscopical examination been unable to verify the existence of secondary degeneration. Cases of defective development, such as porencephalus, should not be operated upon, but, in cases of microcephalus, operation may prove beneficial, although the patient is exposed to great danger. In thirty-seven such cases there were nine deaths.

DR. WILLIAM A. HAMMOND, of Washington, read a paper on "Seven Recent Cases of Brain Surgery," which is to be published in a subsequent number of THE MEDICAL NEWS.

DR. J. H. LLOYD, of Philadelphia, reported a case of tumor of the mesencephalon, and exhibited the specimen.

DR. B. SACHS, of New York, read a paper entitled "Tuberculous Infection of the Central Nervous System," in which he reported two cases of non-tuberculous dis-

ease of the central nervous system in which exposure to tuberculous infection was followed by aggravation of the existing symptoms, with a fatal termination.

DR. E. D. FISHER, of New York, read a paper on "Lead-poisoning with Special Reference to the Spinal Cord and to Peripheral Nerve Lesions," which is to appear in a future number of THE NEWS.

DR. WILLIAM C. KRAUSS, of Buffalo, N. Y., exhibited a neuro-topographical bust, designed to show the topography of the nervous system of the head and neck. The bust is of plaster, life-size, and offers the following special features: The fissures of the brain are represented by grooved lines, deep or shallow, according to the size of the fissures in the human brain. In order to render them more distinct and visible they have been painted black. On the face and neck are represented the various electro-motor points of the muscles and nerves as determined by Erb, v. Ziemssen, and others. The motor points of the nerves are represented by circles, slightly raised and painted yellow. The course of the phrenic nerves and the brachial plexus in the neck are shown by slightly grooved lines, also painted yellow. In contrast to the nerves, the motor points of the muscles are represented by smaller circles, painted red. The various points may be designated by small printed slips or by figures and a reference table.

The bust is recommended for the use of neurologists in making comparisons, and in cerebral surgery as a guide in seeking the various centers of the brain.

THIRD DAY—SEPTEMBER 24TH.

DR. G. L. WALTON, of Boston, reported a case of "Removal of a Neuroma, Followed by Disappearance of Local Anesthesia of Fourteen Years' Standing." Fourteen years ago Prof. B., aged twenty-nine years, cut his left index finger with a chisel. The injury left a sensitive cicatrix over the seat of the nerve, and complete anesthesia of the region supplied by it. Within a year of the date of consultation, numbness and tingling spread up the wrist and forearm, with pain and tenderness of the nerve-trunk (neuritis?). A region of numbness existed on the chest, and another on the thigh. There were general loss of nutrition and troublesome insomnia, with a history of continuous overwork. After a brief trial of general remedies and galvanism (with no result beyond some improvement in general condition), the nerve was cut down upon by Dr. M. H. Richardson. A neuroma was found involving the whole nerve-branch. This, with a portion of the nerve, was removed. The acute symptoms disappeared rapidly, and the long-standing numbness of fourteen years more slowly, sensation in the finger being perfect four months after operation. The case shows that the duration of anesthesia may be practically disregarded in considering the question of operation upon a peripheral nerve.

DR. GEORGE W. JACOBY, of New York, read a paper on "The Electro-physiology of Reflexes, with a Description of a Hitherto Unknown Localized Physiological Reflex Phenomenon." He stated that in the course of his observations he had discovered a reflex contraction of muscles of the chin when the negative pole of a galvanic battery is applied to the radial side of the forearm. Examination of 200 persons showed that the reflex was

present in over 70 per cent. of normal individuals. In no normal case could a reflex be obtained except upon kathodal closure. All kinds of mechanical excitation were also fruitless. In certain pathological cases an anodal reflex was obtainable; in certain others an anodal reflex was produced before a kathodal one, and in still others the contraction showed also a quantitative change.

DR. V. P. GIBNEY, of New York, read a paper on "Supplemental Treatment of the Paralysis of Acute Anterior Poliomyelitis," which appears elsewhere in the current number of THE MEDICAL NEWS.

DR. WALTER CHANNING, of Boston, read a paper entitled "Deformity of the Palate in Idiots." He presented a series of charts and plaster casts showing the formation of the palate in one hundred and fifty cases of idiocy. The cases were classed into average, neurotic, and deformed, of which there were respectively 43, 30 and 37 per cent.

DR. IRVING C. ROSSE, of Washington, read a paper entitled "Triple Personality," in which he reported the case of a man, thirty-five years old, who presented "triple delusions," believing that, in addition to himself, he was a "young man" and "Lucifer." This mental condition had remained unchanged, with the exception of about three months of comparative latency of the delusions nine months before, since when gradual impairment of the mental faculties had left the patient in a state of dementia.

DR. LANDON CARTER GRAY, of New York, read a paper upon "Intra-cranial Syphilis," in which he dwelt upon a complex of symptoms including cephalalgia, irregularly periodical, generally recurring at night, occasionally in the afternoon or in the morning, and associated with insomnia. The symptoms disappeared upon the development of palsy. Dr. Gray maintained that hemiplegia developing in middle age should arouse a suspicion of a syphilitic origin. Headache and insomnia are indicative of an early stage of intra-cranial syphilis, although they may appear later.

DR. MILLS, of Philadelphia, stated that the development of paralysis upon the subsidence of headache and insomnia was unimportant diagnostically and therapeutically. The symptoms occurred as a result of degenerative changes.

DR. WILLIAM OSLER, of Baltimore, read a paper upon "Double Athetosis," based upon fifty-three cases reported and numerous personal observations. He believed that athetosis is compatible with a high degree of intelligence, but is usually accompanied by mental impairment.

DR. CHARLES K. MILLS, of Philadelphia, reported a case in which an apoplectic seizure was followed by deafness, which became more decided after a second attack, with the appearance of partial left-sided paralysis. At the autopsy, lesions were found in the first and second temporal convolutions of both hemispheres. Dr. Mills also reported a case in which a subcortical hemorrhagic cyst was found beneath the arm and leg areas.

DR. JAMES HENDRIE LLOYD, of Philadelphia, read a paper entitled "Tumor of the Mid-brain and Left Optic Thalamus," which is to appear in THE MEDICAL NEWS.

DR. J. J. PUTNAM, of Boston, referred to the case of a child with double athetosis, in which post-mortem no lesion could be found. At the autopsy in a case of

hemichorea, there was a distinct spot of softening in the tegmentum of one side; in another patient, with locomotor ataxia without impairment of intelligence, there was a linear hemorrhage in the subcortical area beneath the paracentral lobule, with secondary degeneration in the cord. In a case of sensory aphasia operated upon, a cyst was found in the left temporal lobe.

DR. L. C. GRAY, of New York, reported the case of a man with hemiplegia and impairment of the muscular sense, in which, on operation, no lesion could be discovered. Death took place a day later. The autopsy revealed at the junction of the arm and leg centers a round-cell sarcoma undergoing cystic degeneration at the center.

DR. C. L. DANA, of New York, reported the case of a man, forty-three years old, with a history of syphilis ten years previously, who presented headache, left hemiconvulsions and coma. On recovery, left hemiplegia and left hemianesthesia persisted. At the autopsy a gumma of the dura mater over the right central convolutions was found. In another case, in a man fifty-five years old, with progressive right hemiplegia and some loss of sensibility on the same side, a tumor about as large as a hen's egg was found in the middle of the left precentral convolution. Dr. Dana held that cutaneous sensations must have their representation in the cortex, having a larger and more diffuse representation than the motor. When one side is involved in disease, compensation takes place from the other side to a greater degree than in the case of motion or other sensations.

DR. PHILIP C. KNAPP, of Boston, reported the case of a child with athetosis from cerebral palsy, in which the autopsy disclosed hydrocephalus and basilar tuberculous meningitis. In another case, anesthesia was associated with a lesion of the motor cortex. He conceded that tactile sensibility was more largely represented posteriorly than anteriorly to the fissure of Rolando. Conversely, growths in the Rolandic region may occasion no motor paralysis.

DR. J. W. PUTNAM, of Buffalo, reported a case in which, shortly after the removal of nasal polypi, memory became impaired. On the eighth day, owing to the absence of sensory or motor symptoms, a diagnosis of abscess of the left frontal lobe was made. On trephining, three ounces of pus were removed from the frontal lobe. At the autopsy, a second abscess was found in the frontal lobe of the opposite side. In another case, in which there was a spastic condition of all four extremities, a glioma at the base was found pushing the medulla to one side. In a child with athetosis involving the head as well as the extremities, there was an apparent absence of the bridge of corpus callosum and an abscess of each temporal lobe.

DR. BREMER reported a case of excision of the wrist-center on the right side for focal epilepsy, in which neither paralysis nor other symptom followed the operation. The question of cortical motor and sensory areas is still unsettled. In the presence of spastic symptoms, the location of the tumor is not so important as is its character. The varying supply of blood to the hemorrhagic cyst probably occasions spastic symptoms.

In conclusion, DR. MILLS expressed the view that there exists a great sensory lobe, not the gyrus fornicatus or the hippocampal region, but a lobe with

anatomical demarcations. It may include the gyrus fornicatus, the quadrate lobe, and the posterior parietal lobule. These regions constitute subdivisions of this sensory lobe, corresponding to subcutaneous muscular groups. Dr. Mills thought that there must be a sensory-motor association tract as well as a sensory-motor audition tract. Cerebral paresthesia is comparable to paraphasia and paralexia.

DR. C. EUGENE RIGGS, of St. Paul, reported a case of paranoia in a young man who, in addition to other symptoms, had periods of double consciousness. The question was raised whether the patient's actions were prompted by the morbid egoism so common in paranoia or constituted a manifestation not infrequently associated with epilepsy.

DR. DAVID INGLISS, of Detroit, read a paper, entitled "Friedreich's Disease; Its Relation to Conducting Paths in the Cord," in which he developed the conclusion that the function of the posterior columns and of the direct cerebellar tract is not to transmit sensory impulses upward, but rather that they are the main channels for the transmission of coordinated motor impulses downward. The anatomical relations of these tracts with the mid-brain and the cerebellum indicate that the tracts transmit coordinated impulses from the higher to the lower centers.

The paper of DR. J. T. ESKRIDGE, of Denver, on "Gunshot Wound of the Left Cuneus with Right Homonymous Hemianopsia," will appear in a later number of THE MEDICAL NEWS.

The paper by DR. C. H. HUGHES, of St. Louis, on "The Virile Reflex in Relation to Clinical and Forensic Neurology," was read by title. Dr. Hughes discussed his method of eliciting the "virile reflex," and set forth its relation to the analogous bulbo-cavernous reflex of M. Ouvanoff.

The novice, in seeking to elicit the clinical and physiological sign, may be inclined to doubt its existence, because some skill in palpation, a sort of *tactus eruditus*, is necessary in examining for it. The characteristic jerking-back of the bulbous urethra within the sheath of the penis can be felt only when carefully sought for, and it cannot ordinarily be seen.

The value of this sign in its clinical aspect is obvious, and in its medico-legal relations it must likewise be apparent, especially in questions of exaggerated, perverted, or lost virility. By it we may be aided in the solution of questions of morbid erotism, erotomania, nymphomania, satyriasis, psychical or physical lust, questions of rape from rational and purely lustful purpose or from morbid perversion and insane impulse, etc.

The paper of DR. J. T. ESKRIDGE, of Denver, entitled "Fracture of the Twelfth Dorsal Spine, Followed by Injury of the Spinal and Sympathetic Nerve-supply of the Bowel in the Region of the Ileo-cecal Valve, Intestinal Hemorrhage, and Death on the Seventh Day," appears in the current number of THE MEDICAL NEWS.

The following were elected to active membership: Dr. H. A. Tomlinson, of Philadelphia; Dr. Edward Cowles, of Somerville, Mass.; Dr. Henry H. Donaldson, of Worcester, Mass.; Dr. James Wright Putnam, of Buffalo, N. Y.; Dr. William Browning, of Brooklyn, N. Y.; Dr. Edward B. Angell, of Rochester, N. Y.; Dr. G. J. Preston, of Baltimore, Md.; Dr. Richard Dewey,

of Kankakee, Ill.; Dr. Walter Channing, of Boston, Mass.

The following officers were elected for the ensuing year:
President.—Dr. C. L. Dana, of New York.

Vice-Presidents.—Dr. P. C. Knapp, of Boston, and Dr. E. N. Brush, of Baltimore.

Secretary and Treasurer.—Dr. G. M. Hammond, of New York.

Councillors.—Dr. Wharton Sinkler, of Philadelphia, and Dr. E. D. Fisher, of New York.

AMERICAN DERMATOLOGICAL ASSOCIATION.

Fifteenth Annual Meeting, held at Washington, September 22, 23, 24, and 25, 1891.

(Continued from p. 371.)

SECOND DAY—SEPTEMBER 23D.

DR. J. C. WHITE, of Boston, opened the discussion on Tuberculosis of the Skin. He presented "Its Clinical Aspects and Relations."

DR. JOHN T. BOWEN, of Boston, considered "The Pathology of Cutaneous Tuberculosis." He confined himself to the anatomy of the affection.

Baumgarten has shown that the fixed tissue-cells are the first to become impressed by the tuberculous virus, and are converted into epithelioid and giant-cell forms. While it may be questioned whether we are yet justified in regarding the epithelioid and giant-cells as derived in all instances from the fixed tissue-cells alone, it is now clear that the rôle of the white blood-corpuscles in tuberculosis, as well as in other chronic inflammatory processes, has been greatly exaggerated.

Four distinct varieties of cutaneous tuberculosis may be considered, viz.: miliary tuberculosis, scrofuloderma, lupus, and tuberculosis verrucosa cutis. Miliary tuberculosis of the skin occurs rarely. It is found at the entrance to mucous cavities, in persons suffering from advanced tuberculosis of internal organs, and is characterized clinically by painful ulcers with indented edges. Anatomically, this form of tuberculosis presents the characteristics of an acute process, with the presence of a large number of tubercle bacilli, and an advanced stage of necrosis. It is analogous to the acute tuberculosis of internal organs. Scrofuloderma represents a tuberculosis of the subcutaneous tissue and lower layers of the corium, and the tubercle bacilli, while less numerous than in the miliary form, are usually found in greater numbers than in lupus. In lupus the process has its starting-point in the lower portions of the corium, affecting the upper portions by extension. Lupus differs from other forms of tuberculosis in being less acute and more slowly progressive.

It was maintained that in tuberculosis verrucosa cutis the inflammatory complications, which are pronounced in some cases, are by no means constant. The number of tubercle bacilli found in the lesions may be small. Anatomically, tuberculosis verrucosa differs from lupus verrucosa in its more superficial seat, and in the early appearance of the papillary hypertrophy; the verrucous forms of lupus are usually consecutive to some degree of ulceration. In tuberculosis verrucosa cutis a direct inoculation can usually be proved to have taken place,

a mode of infection that has as yet been demonstrated in only a small number of cases of lupus.

DR. G. H. FOX, of New York, discussed "The Treatment of Tuberculosis of the Skin."

In the subsequent discussion DR. H. G. PIFFARD, of New York, said that the connection between what was called pulmonary consumption and lupus and the so-called scrofulodermata had long been surmised. Recent advances in microscopy had enabled the detection of tubercle bacilli in the lesions, and to establish the relationship on pathological grounds. Dr. Piffard expressed the belief that lupus erythematosus is entitled to the name "lupus," as he thinks it too is of bacillary origin. Cold abscess of the skin is probably due to the same cause, as is also rodent ulcer. He agreed with Dr. White in believing that there should be a collective term for all of the various tuberculous diseases. In treatment he advocated cutting out the whole diseased patch, unless it was very extensive. Next to the knife he placed the actual cautery, after removal with the curette of as much of the growth as possible. Arsenic and chloride of zinc are also to be depended on.

DR. C. W. ALLEN, of New York, commended multiple scarification, and combined pyrogallol and mercurial plasters; he thought that there might yet be a future for tuberculin.

DR. J. ZEISLER, of Chicago, expressed himself as in thorough accord with Dr. White. His experience had converted him to the use of the galvano-cautery. He testified to the efficacy of the solid stick of nitrate of silver, which, bored into the skin, would act both as a knife and caustic. He was not enthusiastic as to tuberculin.

DR. E. B. BRONSON, of New York, believed that it was best to retain for some time our present terminology for the different tuberculous diseases. In regard to tuberculin, he had seen improvement in some cases treated with it, but on the whole his experience had made him regard the remedy unfavorably. He had had good success with the dental burr, as first advocated by Dr. G. H. Fox. The nitrate-of-silver stick was also good.

DR. J. N. HYDE, of Chicago, was glad that Dr. White accepted local contagion as the cause of lupus, a view that he himself was among the first to advocate. He thought that in this country there were but few cases of lupus with a history of pulmonary tuberculosis in the family, or with tuberculous disease elsewhere. He did not believe in the treatment by scarification. Both the curette and nitrate of silver were serviceable in proper cases. In regard to tuberculin, he thought it possible that in time something of value might be found in it.

DR. L. A. DUHRING, of Philadelphia, preferred in private practice for the present to retain the old names. He had not found lupus associated with general tuberculosis. He recommended pyrogallol most highly, using it in the form of a plaster with resin and soap plaster—three of resin plaster and one of soap plaster—to be worn continuously. He had not found the local use of bichloride of mercury beneficial. He had found tuberculin helpful, though he could not report any case of cure.

DR. P. A. MORROW, of New York, agreed with Dr. White that as lupus and some other diseases had a common etiological factor, we should place them together under a common heading. He advocated the use of

multiple scarifications followed by mercurial plaster. For destruction of the small lupus nodules he recommended punctate cauterization with a white-hot instrument. Chloride of zinc is superior to pyrogallol as a caustic. Excision will probably increase in favor as a means of treating lupus.

DR. L. D. BULKLEY, of New York, expressed a want of satisfaction with any of the current plans for the external treatment of lupus. Internally, he has great faith in phosphorus as a curative agent, the nodules softening and disappearing under its continuous use. As to pyrogallol, that too was admirable. He applies it in powder, pure, after scraping. Salicylic acid combined with pyrogallol is also useful.

THIRD DAY.—SEPTEMBER 24TH.

DR. L. A. DUHRING, of Philadelphia, read a paper entitled "Notes of a Visit to the Leper Hospital of San Remo, Italy." In reply to a question he replied that no attempt at segregation was made in San Remo. There were but few cases in the hospital, and they were in an ordinary ward of a general hospital. They were not permitted to leave the confines of the hospital.

DR. P. A. MORROW, of New York, then followed with a paper on "Skin-grafting," and showed a case in which the operation had been done by the method described, with admirable results.

DR. CLARKE asked if the inclusion in the graft of the deeper structures of the skin, as recommended, would give any better results than if the more superficial parts only were included. Dr. Morrow replied that he thought that the deeper grafts would be more certain to take, and he had had not a single failure. He had made more than fifty grafts of hairy skin upon a cicatricially bald scalp, and all of them had taken, and from many of them the hair was growing nicely.

DR. L. D. BULKLEY, of New York, read a paper entitled, "A Therapeutic Note on Alopecia Areata."

DR. J. ZEISLER, of Chicago, believed that alopecia areata was due to a parasite, though perhaps some cases are dependent upon a neurosis. The latter were most obstinate. He was in favor of treating all cases by epilation about the patches. He had no success with pilocarpine. He regarded a concentrated solution of common salt as a good remedy for stimulating the growth of the hair.

DR. W. T. CORLETT spoke in favor of acetic acid as a remedy in alopecia areata. Some cases, however, recover spontaneously.

DR. G. H. FOX was always pleased to hear anyone speak with confidence of any treatment of alopecia areata, as Dr. Bulkley had done of carbolic acid. He was rather skeptical of any remedy. In his hands a strong solution of ammonia had proved as effective as any remedy. He thought that general treatment of the patient was quite as important as any local application.

DR. J. E. GRAHAM had never seen any cases that would lead him to believe that alopecia areata was contagious. He did not think that, because antiparasitic remedies were useful, this was a proof of the parasitic nature of the disease.

DR. P. A. MORROW thought that there had been a sufficient number of cases of contagion reported to remove any reasonable doubt of the contagiousness of the disease.

He quoted an instance in which a number of cases were traced to one barber. He had seen one case of probable contagion.

DR. L. A. DUHRING said that in spite of a careful study of alopecia areata he had never been able to find any parasite in the disease; nor was he convinced that the disease was contagious. He believed that there was a disease simulating alopecia areata, and often reported as such, that sometimes occurred epidemically, but was not alopecia areata. He regarded arsenic taken internally as very valuable in the treatment of the disease. He could see no reason for epilating the healthy hair about the patches.

DR. J. C. WHITE said that positive evidence of both the parasitic and the neurotic element in the etiology of the disease was still wanting. Clinical evidence points both ways. He had seen cases of apparent contagion. He had seen thirty cases of a disease simulating alopecia areata occurring in an asylum, which were not cases of ringworm, but were probably instances of so-called contagious alopecia areata. He did not think that they were true alopecia areata. His favorite remedy was a lotion consisting of half a dram of croton oil to eight ounces of turpentine, used daily. Of course, it failed in some cases, as do all remedies. If it failed, he used other remedies that had been commended, but they did not do any better. He did not believe that there was any specific remedy.

DR. H. W. STELWAGON had never been able to trace a case to a contagious origin. Local stimulation is more to be relied on in treatment. He was fond of equal parts of turpentine, cantharides and tincture of capsicum, with arsenic internally.

DR. J. N. HYDE believed that the time would come when alopecia areata would be regarded as simply a symptom. Some cases were doubtless parasitic and some neurotic in origin. In bad cases he used creasote locally. After, say, from the forty-fifth to the forty-eighth year of life, the chances of recovery are greatly decreased.

DR. H. G. KLOTZ had had one case in which hereditary syphilis was probably the underlying cause, the boy getting better under specific treatment.

DR. W. C. ALLEN believed that the disease was parasitic and thought that he had in his own practice observed a case of contagion. He thought that internal treatment was valuable. Naphthol and pyrogallol had both proved useful in his hands.

DR. J. GRINDON had never met with a case that suggested either a parasitic or contagious origin of the disease. He believed in its tropho-neurotic origin.

DR. F. B. GREENOUGH in practice used a half-dram of carbolic acid in an ounce of water as a lotion.

DR. L. D. BULKLEY said that he applied the 95 per cent. solution of carbolic acid to a small portion only of the scalp at a time. It should be brushed over lightly at first, so as to benumb sensibility, and then rubbed in more thoroughly. He had not used it elsewhere than on the scalp. The skin is red for a few weeks; this disappears and the hair grows. He also administers strychnine and phosphoric acid, and keeps up the nutrition of the patient.

DR. R. W. TAYLOR, of New York, read a paper entitled "Angioma Pigmentosum et Atrophicum," by DR. A. W. BRAYTON, of Indianapolis.

DR. J. C. WHITE stated that his investigations showed that the disease was not limited to Russian Jews, but was met with also in persons of English and of French descent.

DR. L. A. DUHRING read a paper entitled "Experiences in the Treatment of Chronic Ringworm in an Institution for Boys."

In the discussion, DR. G. H. FOX said that he had found chrysarobin useful, as had Dr. Duhring. He began the treatment by clipping the hair short and shaving, either only over the patches or over the whole scalp, and applying chrysarobin in solution. He disliked greasy applications. Hydronaphthol plaster, as recommended by a European physician, had proved more satisfactory than chrysarobin. He advocated epilation when practicable.

DR. J. ZEISLER advocated pyrogallol as a parasiticide.

In reply to a question, DR. DUHRING said that some of the cases recovered in six weeks, and some not for a year.

DR. WHITE thought that white chrysarobin was a good remedy; it was not a safe one to use outside of an asylum or hospital. He recommended a combination of sulphur, carbolic acid, and naphthol, made into an ointment.

DR. STELWAGON recommended an ointment composed of tar, sulphur, and citrine ointment.

DR. SHERWELL advised keeping the scalp saturated with a mild oil and covered by a skull-cap.

In concluding, DR. DUHRING said that the cases were all well when the treatment was withdrawn, and that they remained well for at least one year. Epilation did not repay the vast amount of labor it cost. He regarded ointments as most useful remedies.

DR. J. ZEISLER, of Chicago, then read a paper on "Epilation: Its Range of Usefulness as a Dermatotherapeutic Measure."

In the discussion, DR. G. H. FOX said that he was glad to hear anyone advocate epilation in sycosis, as he had found it a most useful remedy. After epilation, a sulphur paste is valuable. He had not found epilation so promptly curative as had Dr. Zeisler, while he laid more stress on dietetic management than did the latter. He was sure that epilation was useful in some cases of chronic ringworm of the scalp.

DR. H. G. KLOTZ also spoke in favor of epilation in sycosis, though he had cured many cases without it, notably with mild naphthol ointments. He thought epilation valuable in syphilitic lesions about the hairs, as well as in all the pustular affections implicating the hair.

DR. L. A. DUHRING had not been able to practise epilation on his patients on account of the pain it caused, especially on the upper lip. He could not see much use in epilating in alopecia areata when the hairs about the patch were firm.

DR. P. A. MORROW said that he did not think it necessary to pull out all the hairs about the bald patches, but it was a good thing to make traction on all of them and to remove all that were loose. Epilation was a requisite in all rebellious cases of trichophytosis. If the hair is removed by a quick, sudden movement, the operation is nearly painless.

DR. H. W. STELWAGON believed that many cases of

sycosis could be cured without epilation. He would speak in special praise of Fleming's solution in trichophytosis, diluting it at first one part to five or six of water, and gradually increasing the strength to just short of marked irritation.

DR. S. SHERWELL spoke of the connection between catarrhal conditions of the nose and sycosis of the upper lip.

DR. J. H. HYDE said that the last time he was in London and Paris he had observed that epilation was quite generally practised about the patches of alopecia areata.

In closing, DR. ZEISLER said that when epilation was properly performed it was almost painless. As he regards alopecia as a parasitic disease, spreading at the periphery, he epilated about the patches to stop their spreading.

FOURTH DAY—SEPTEMBER 25TH.

DR. J. E. GRAHAM, of Toronto, read a paper on "Molluscum Contagiosum."

DR. BOWEN said that there was little question but that the disease was contagious. It is still unproved whether certain bodies found in molluscum are or are not coccidia.

DR. ALLEN had no doubt about the contagiousness of the disease, and related cases in an asylum spreading from one case. Excision is never necessary. The nodules can readily be squeezed out, and then lightly touched with a caustic. He believed in their parasitic origin.

DR. J. C. WHITE, while believing that molluscum was contagious, was not prepared to accept the psorosperm as its cause.

DR. J. N. HYDE pointed out that in the statistics for the year just closed, 17 cases of molluscum contagiosum were reported, viz.: 9 from Boston, 5 from New York, 2 from Chicago, and 1 from St. Louis.

DR. F. B. GREENOUGH believed the disease to be contagious. In treatment he simply bores into the formation with nitrate of silver stick.

DR. J. E. GRAHAM thought from evidence so far brought forward that the so-called psorosperms were simply degenerated epithelial cells.

DR. J. N. HYDE, of Chicago, then read a paper entitled "Note Relative to Pemphigus Vegetans."

In the discussion, DR. L. A. DUHRING said that he had had the opportunity of seeing the case described and would corroborate what Dr. Hyde had said of it. It certainly was more of the nature of pemphigus than of anything else.

DR. BOWEN had seen a case of Neumann's in Vienna, and this one brought that one back very vividly to his mind. He regarded the term "pemphigus" as a most indefinite one, and thought that it gave very little idea of the pathology of the case under discussion.

DR. S. SHERWELL had seen a case in a woman with analogous symptoms, which was cured by ovariectomy.

DR. J. E. GRAHAM related the history of a similar case of his own. It became much better under arsenic but suffered a relapse.

DR. J. N. HYDE, in closing, said that in his case there was no disease of the ovaries. He regarded the prognosis in his case as not good.

DR. H. W. STELWAGON then read a paper on "A Study of Mycosis Fungoides."

DR. HARTZELL emphasized the infectious nature of the tumors, and thought that we must look to inoculation experiments for proof.

DR. BOWEN spoke of the disagreement among pathologists in regard to the exact nature of the tumors.

DR. DUHRING said that the disease was a general one of the skin, and did not to any extent seem to affect other organs. He believed it to be an infectious disease. It may be regarded as on the border-line between an inflammatory new-growth and a tumor.

DR. FOX related a case of apparent infection of the disease in the New York Skin and Cancer Hospital. He also spoke of the early diagnosis of the disease, and reported a case that at first looked like eczema marginatum, but afterward developed the characteristic tumors.

DR. STELWAGON, in closing, said that in looking up the literature of the disease he had found some fifty or a hundred reported cases. It was exceptional for the disease to begin as tumors.

DR. M. B. HARTZELL, of Philadelphia, then read a paper on "Lymphangioma Circumscriptum, with Report of a Peculiar Case," which is to appear in THE MEDICAL NEWS.

DR. C. W. ALLEN then made some remarks on "Erythema or Nævus Nuchæ."

DR. ZEISLER thought it probable that erythema nuchæ was often due to pressure and rubbing.

DR. JOSEPH GRINDON, of St. Louis, Mo., read a paper on "A Case of Lichen Ruber." This case is placed under the above caption inasmuch as, although differing in several important particulars from the hitherto reported American cases, it tallies in most points with the descriptions of the younger Hebra. The writer believes that the constitution and limitations of the lichen group are still far from being settled, and would provisionally class as lichen ruber cases of chronic papular inflammatory dermatoses not readily falling in with any of the other better-defined members of the group, such as *L. planus* or *L. scrofulosus*.

The disease in this instance was characterized by the formation of firm, hard, red papules of rounded outline and profile, little or not at all scaly, intensely pruritic, of very slow evolution, occurring first on the face and after several years spreading to the body and extremities. The hairs and nails were implicated, but there was no marked depreciation of the general health. The papules after a longer or shorter interval tended to form patches, by the appearance of new lesions among the older ones. These patches finally lost all trace of a papular origin, but were divided up by deepening of the normal furrows, consequent upon the thickening and infiltration. The disease showed several partial remissions, and one period of apparent cure extending over several months. The best results were obtained from the persistent use of Unna's carbolic-sublimite salve. Arsenic had no appreciable effect.

DR. ZEISLER was inclined to view the case as one of lichen planus. In this disease plantar and palmar thickenings are apt to form. Arsenic often cures these patients.

DR. S. SHERWELL agreed with Dr. Zeisler in his diag-

nosis, though the case presented many exceptional features, especially the involvement of the nails.

DR. HYDE said that he always found the polygonal outline of the papules to be well marked, something that does not seem to be familiar to the Germans and the French.

DR. DUHRING agreed with the previous speakers in this diagnosis. The polygonal shape and umbilication are often wanting.

AMERICAN LARYNGOLOGICAL ASSOCIATION.

*Thirteenth Annual Meeting, held at Washington,
September 22, 23, and 24, 1891.*

FIRST DAY—SEPTEMBER 22D.

DR. W. C. GLASGOW, of St. Louis, delivered the Presidential Address, in which he reviewed the progress of the science of laryngology, and especially the influence that had been exerted by the American Laryngological Association, in rescuing the practice of laryngology from charlatans and giving it a prominent and honorable position among the special fields of practice. Appropriate action was taken with regard to the death of Dr. E. Carroll Morgan, who, as President of the Association, occupied the chair at its last meeting in Washington, two years ago. A minute was also made of the death of another member, Dr. Hosmer A. Johnson, of Chicago, who died since the last session.

DR. GLASGOW read a paper entitled "A Case of Foreign Body in the Trachea." A child, eight years old, was said to have swallowed, two hours previously, a toy balloon with a whistle attached. There were paroxysms of suffocation, in the intervals between which the child appeared to be perfectly well, without any interference with respiration. While under examination, the child suddenly became aphonic, struggled for breath, lost consciousness, and frothed at the mouth. The paroxysm passed off in a few minutes, and the child resumed its normal condition. It could swallow water, and a bougie had been passed into the stomach, showing that the esophagus was clear. By inspection, the larynx appeared unobstructed. Chloroform anesthesia was so poorly borne that a thorough examination was not made. It was concluded that the manifestations were hysterical or epileptic. Finally, after tracheotomy was performed, the rubber part of the balloon was seen to project into the lower part of the tube, and was extracted through the tracheal wound; subsequently the wooden whistle was extruded through the glottis, and the child recovered. In the interval between the paroxysms there was slight enfeeblement of breathing over the left lung.

DR. CLINTON WAGNER, of New York, read a paper entitled "A Case of Thyrotomy in a Child Eighteen Months Old." He said that thyrotomy should only be resorted to for the relief of urgent dyspnea arising from laryngeal obstruction, either by a benign growth or a foreign body, in order to accomplish the removal of such obstruction. In a case of malignant disease, it is only permissible when there is a reasonable chance of removing all diseased tissue. In tuberculosis of the larynx it is unjustifiable. Dr. Wagner had performed the operation ten times; six of the cases perished, but not as a result of the operation. The remaining four cases, all

in children, recovered. The case reported was that of a neglected child suffering with dyspnea, the cause of which was uncertain. Two weeks after a preliminary tracheotomy, thyrotomy was performed, and a small papilloma was detected near the posterior extremity of the left cord and removed. The child did well for ten months after the operation, when he succumbed to an attack of croup.

In the discussion, DR. INGALLS, of Chicago, advocated the use of the index-finger for diagnostic purposes.

DR. MULHALL, of St. Louis, commended the finger-nail as a useful instrument for the removal of small superficial papillomata of the vocal bands.

In young children, under two or three years of age, DR. WAGNER considered the removal of papillomata by the mouth entirely impracticable.

DR. HARRISON ALLEN, of Philadelphia, read a paper on "The Tonsil in Health and Disease." He considers the tonsils analogous to Peyer's patches in the small intestine. He held the operation of amputation of the tonsils as unscientific and unnecessary. In many cases, the enlargement of the tonsils subsides without direct treatment, if the adenoid tissue in the naso-pharynx is restored to a healthy condition. Dr. Allen therefore recommended primary operation upon existing pharyngeal growths. When bands of cicatricial tissue stretch across the surface of the tonsil, obstructing the openings of the crypts of the gland, he advocated cutting such bands in order to relieve tension and favor expulsion of the contents of the crypts. Subsequently, astringent applications are made by means of a probe carried into the crypts, which Dr. Allen prefers to the cautery or knife.

DR. JONATHAN WRIGHT, of Brooklyn, said that it was his experience that when he removed a pair of enlarged tonsils, the adenoid tissue above disappeared spontaneously. He held that the tonsils both caused irritation and dammed up the secretions, and thus led to pharyngeal disease.

DR. JOHN O. ROE, of Rochester, advocated the evacuation of abscess in the tonsil by means of sharp scissors, which are used closed as a probe and opened only after introduction, cutting only so much as may be needed and avoiding large vessels.

DR. CLARENCE C. RICE, of New York, read a paper on "The Troublesome Symptoms Caused by Enlargement of the Epiglottis and the Advisability of Reducing the Size of this Cartilage by Operative Measures." Many deformities of the epiglottis are recognized, especially those occurring in the course of pulmonary tuberculosis, lupus and syphilis. When the epiglottis is the seat of a chronic morbid process, or the lingual tonsil is enlarged so as to cause irritation, there arise a sense of fulness and tickling in the throat and frequent cough. In addition to the edema, tumefaction and inflammatory swelling of the overlying tissues, the cartilage itself is actually increased in size. The epiglottis may congenitally be abnormally large; more frequently the increase in size is caused by injuries, the excessive use of tobacco, alcohol, and by local inflammatory disturbances. Under the latter conditions Dr. Rice advised the removal of a portion of the enlarged part with long-bladed scissors or cutting-forceps. He had operated thus in two cases, using cocaine applications followed by albolene. He did not approve of the employment of the

epiglottitome of Mackenzie, and had found the galvano-cautery objectionable because the resulting burns are long in healing. The same objection applies to the use of the hot snare. The operation of removing part of a permanently enlarged epiglottis is applicable for cases in which astringents and ordinary treatment have failed.

DR. WAGNER stated that in a case of carcinoma of the epiglottis, reported ten years ago, he removed the entire epiglottis by the sub-hyoidean method, and no ill-effects followed. Dr. Wagner considered the partial removal advocated by Dr. Rice a justifiable procedure.

In the discussion on the "Result of Treatment of the Upper Air-passages in Producing Permanent Relief in Asthma," DR. BOSWORTH insisted upon a recognition of the general morbid condition in cases of true asthma. He distinguished three factors in every attack: 1, The peculiar neurosis; 2, some external, perhaps atmospheric, excitant; and 3, frequently some local condition in the nose that entails unusual susceptibility to certain irritants. In a large proportion of cases a restoration of the normal respiratory function and a removal of obstruction from the nose or upper air-passages confers immunity from future attacks.

DR. BOSWORTH did not insist upon a nasal factor in every case of asthma, but when such abnormality was found it should receive appropriate treatment.

DR. MULHALL, of St. Louis, presented a right-angled laryngeal cutting-forceps with a novel hinge.

DR. ASCH, of New York, presented a new intra-nasal galvano-cautery electrode, with the handle at an angle, so as not to obstruct the view.

SECOND DAY—SEPTEMBER 23D.

DR. JONATHAN WRIGHT, of Brooklyn, read a paper on "Nasal Papillomata." He contended that nasal papillomata are extremely rare, and that the name is misleading. He preferred the designation "papillomatous fibroma." What have generally been mistaken for papillomata, upon investigation prove to be ordinary hypertrophic inflammatory masses or glandular hyperplasia, principally involving the inferior turbinated body. True papillomata, as a rule, occur upon the septum, in conformity with the observation that the muco-cutaneous junctions are the favorite sites for epithelial proliferations.

DR. JARVIS advocated the employment of chromic acid to cauterize the bases of these growths after their removal, which always prevents their return.

DR. J. SOLIS-COHEN proposed the name of dendritic vegetations for the so-called papilloma.

DR. E. L. SHURLY, of Detroit, read a paper entitled "A Study of a Case of Nasal Tuberculosis." The subject was a monkey with nasal catarrh and a profuse discharge containing tubercle bacilli. The discharge was diminished by the employment of antiseptics. The monkey was subsequently killed, but no tuberculous lesions were detected in the lungs or other viscera. It appeared to be simply a case of local tuberculous infection limited to the nose.

DR. CHAS. L. KNIGHT, of New York, read a paper on "Cysts of the Middle Turbinated Bone." He considered the affection rather frequent, but often unrecog-

nized. Of the two theories proposed to account for the development of the cysts—(1) rarefying osteitis, and (2) hypertrophic rhinitis—he believed the latter the more probable. An ossific projection growing from the middle turbinated bone gradually curls upon itself until, finally meeting the body of the bone, it forms a closed cavity. Such cavity, being lined with ciliated epithelium, contains mucous secretion, and, if inflamed, muco-pus. Operative treatment is simple: the cyst cannot be removed entire, but is extirpated, and antiseptic dressings are applied. These cysts occur only in connection with the middle turbinated bone, and none of the cases was under twenty years of age.

DR. F. H. BOSWORTH, of New York, read a paper on "Various Forms of Ethmoid Disease," based on an analysis of twenty-seven cases that had been under treatment during the past five years. He distinguished five varieties, reporting illustrative cases of each: First, extra-cellular myxomatous degeneration, without purulent discharge; second, extra-cellular myxomatous degeneration, with purulent discharge; third, purulent ethmoiditis with nasal polypi; fourth, intra-cellular myxomatous degeneration without pus; and, fifth, intra-cellular myxomatous degeneration with pus.

The second variety may be regarded as a later stage of the first, while the fifth is a later stage of the fourth, thus reducing the varieties to three. For the first and second, as well as for the fourth and fifth varieties, no definite cause was assigned. The third variety may be regarded as the direct result of the nasal polypi, and not as a cause, as has been stated. This view is substantiated by the fact that in a majority of cases the ethmoid disease was accompanied with purulent disease of the antrum.

The diagnosis is based on careful ocular inspection, and a nice tracing of the source of pus-discharge. The diffuse myxomatous degeneration, so frequently seen covering the middle turbinated bone, should in the majority, if not in all cases, be accepted as evidence of a diseased condition of the mucous membrane lining the ethmoid cells. The treatment of all forms consists in uncovering the ethmoid cells by removing the convex cap of the middle turbinated body by means of the snare, and subsequently breaking up and destroying, as far as possible, the trabeculae by means of the electric burr or the curette.

DR. W. E. CASSELBERRY, of Chicago, read a paper on the "Radical Treatment of Nasal Myxomata," in which the ground was taken that the best results follow extirpation of the base from which the myxomata grow. In two-thirds of the cases, myxomata develop in connection with or beneath the middle turbinated bone. They rarely develop from flat surfaces, but generally from free borders or edges. From the effects of hypersecretion the mucous membrane becomes sodden and furnishes a good soil for the growth of myxomata. Such a soil is found upon the free edge of the middle turbinated bone, and hence the frequency of their occurrence in this situation. These growths may be removed with curved scissors or with punch-forceps, and if part of the bone is removed at the same time it is generally an advantage, although not too much should be taken away for fear of occasioning cerebral mischief. The site of the growth can be touched with the cautery.

THIRD DAY—SEPTEMBER 24TH.

DR. J. SOLIS-COHEN, of Philadelphia, considered "The Symptoms and Pathological Changes in the Upper Air-passages in Influenza." The prominent changes are lymphoid infiltration of the soft parts, causing more or less edematous swelling of the soft tissues. The disease affects both the lymphatic and sanguineous vascular systems, differing in its manifestations in accordance with the structures most affected. Dr. Cohen incidentally mentioned a curious effect of influenza upon the course of other disease. In an old gentleman suffering with epithelioma of the palate, the patch of malignant disease sloughed during an attack of influenza and perfect recovery ensued.

DR. W. C. JARVIS, of New York, presented a communication entitled "Useful Deductions Derived from the Study of a Case of Cicatricial Contraction of the Larynx, Possessing Unusual Clinical Features, with Exhibition of Specimen."

DR. J. SOLIS-COHEN examined the specimen and said that below the constriction there was a normal larynx.

DR. MACKENZIE reported a case in which attacks of dyspnea were caused by a gumma that compressed both recurrent laryngeal nerves. The trachea had its lumen so narrowed above its bifurcation that it was with the greatest difficulty that a fine probe could be passed through the stricture. Tracheotomy was performed, but the dyspnea was not relieved, and after death the condition reported was found.

DR. ASCH suggested intubation and dilatation, with tracheotomy, if necessary.

DR. MORRIS J. ASCH, of New York, reported "A Case of Epithelioma of the Larynx." The patient was a healthy, vigorous man, fond of hunting, and unusually strong and active. He naturally had great irritability of the larynx, rendering examination difficult. The symptoms began with hoarseness and pain. In a few months the characteristic appearances of carcinoma of the larynx developed, with cough and dyspnea. Preliminary tracheotomy was performed, and subsequently the larynx was extirpated. In performing tracheotomy, Dr. Asch recommended the injection under the skin along the line of incision of a few drops of a 2 per cent. solution of cocaine as a local anesthetic, in preference to the employment of ether or chloroform, to produce anesthesia. By this means the operation is made absolutely painless. The patient was relieved, but subsequently had attacks of spasmodic dyspnea, during one of which he died, while suffering from weakness due to influenza.

DR. J. N. MACKENZIE, of Baltimore, presented a communication entitled "The Laryngo-tracheal Neoplasms of Tuberculosis." He recognized the following varieties: (1) That which is ordinarily known as papillary hyperplasia. (2) Papillary, warty growths, having nothing to distinguish them clinically from ordinary papillomata. These may be removed with the cold snare, but in tuberculous neoplasms, operations are deprecated, unless the growth, by its size, encroaches to a dangerous extent upon the lumen of the tube. (3) A solitary form of tuberculous tumor first described some twelve years ago by Dr. Mackenzie.

In the discussion on "The Relation of Disturbance of the Mucous Membrane of the Upper Air-passages to Constitutional Conditions," DR. MULHALL spoke in favor

of hygienic treatment of nasal catarrh, and cited two cases in which the symptoms disappeared after the patients, who were pugilists, went into training.

DR. S. SOLIS-COHEN defined struma as a consequence of hypotrophy.

The following officers were elected for the ensuing year:

President.—Dr. S. W. Langmaid, of Boston.

Vice-Presidents.—Dr. Morris J. Asch, of New York; Dr. S. Johnston, of Baltimore.

Secretary and Treasurer.—Dr. Charles H. Knight, of New York.

Librarian.—Dr. Thomas H. French, of Brooklyn.

Member of Council.—Dr. William C. Glasgow, of St. Louis.

It was voted to ratify the action of the Council in transferring the Library to the Surgeon-General's office, where it will be held intact.

After some discussion, the limit of membership was increased from fifty to seventy-five.

Dr. J. H. Bryan, of Washington, D. C., was elected a Fellow of the Association.

The next meeting will be held at Boston, at a time to be fixed by the Council.

AMERICAN PEDIATRIC SOCIETY.

*Third Annual Meeting, held at Washington,
September 22, 23, 24, and 25, 1891.*

(Continued from p. 384)

THIRD DAY—SEPTEMBER 24.

DR. W. P. WATSON read "A Report of a Case of Tuberculous Ostitis of the Hip-joint in a Child Born at Colorado Springs," by DR. JOHN M. KEATING, of Philadelphia. The father was in an advanced stage of pulmonary tuberculosis when the child was born. The boy was six years old and the picture of health. The case is a rare one, as Dr. Keating could find the records of only five or six cases of tuberculous joint-disease originating in Colorado Springs during a period of more than fifteen years, though a large portion of the population of 15,000 are or have been tuberculous.

DR. CHARLES W. EARLE, of Chicago, was not present, and his paper, entitled "Manifestations of La Grippe in Children," was read in abstract by DR. A. SEIBERT, of New York.

DR. J. O'DWYER, of New York, gave an exhibition of laryngeal tubes for the performance of forcible respiration. The instrument consists of a hollow, annulated cone, which is screwed to a curved tube with two openings, the upper being surrounded by a metal shield and the lower being supplied with a rubber tube attached to an ordinary laboratory bellows.

Dr. O'Dwyer stated that the cone could be easily placed in the larynx through the mouth and that the ringed grooving would keep it from slipping. By working the bellows, forcible inspiration could be maintained for any length of time necessary. During expiration the fingers should be withdrawn from the shielded opening. The apparatus was offered as presenting advantages for the treatment of opium-poisoning, and other cases requiring artificial respiration.

DR. WILLIAM OSLER, of Baltimore, read a paper on

"The Association of Congenital Wry-neck and Facial Hemiatrophy," reporting an illustrative case.

DR. CHARLES G. KERLEY, of New York (by invitation), read a paper on "The Application of Gavage in the Treatment of Uncontrollable Vomiting in Infants."

He advocated the use of a No. 13 Paine's adult nasal feeding-tube as preferable to the catheter that is used in gavage. The operation should be done quickly and predigested food only should be introduced into the stomach.

DR. A. SEIBERT believed that in catarrhs of the stomach in babies, a similar condition exists in the mouth and throat. By the use of the tube, food would reach the stomach without receiving bacteria from the upper passages.

DR. W. P. NORTHRUP, of New York, read a paper on "Scorbutus in Children," illustrated by microscopic slides and drawings. Twenty-five typical cases of scorbutus in children were collected. Great stress was laid upon pain and swelling over the femora, with spongy gums, and the prompt recovery under proper diet as being almost diagnostic. Oranges proved most grateful to the patients.

DR. PUTNAM reported that he had observed three cases of scorbutus in children. He thought that proprietary foods and condensed milk had much to do with its production.

DR. JACOBI, of New York, stated that he had missed the definition of the disease scorbutus. He desired information as to whether bleeding from the gums should be considered a characteristic feature.

DR. NORTHRUP regarded subperiosteal hemorrhage with some swelling of the gums, with or without bleeding, as due to scurvy. The recovery under anti-scorbutic diet would confirm the diagnosis.

DR. J. LEWIS SMITH, of New York, read a paper on "Scarlatinal Nephritis," in which he expressed the view of a microbic origin of the nephritis of scarlatina. At the same time, he cautioned against the risk of exposure to cold in the management of cases of scarlatina.

DR. SEIBERT, of New York, believed that in many cases of acute nephritis in the course of scarlatina there was some cause for the disease. He had seen nephritis after acute attacks of tonsillitis and varicella. He advocated treating cases of scarlatina in well-ventilated rooms, even though cold.

DR. FORCHHEIMER, of Cincinnati, thought that the predisposing influence of scarlatinal nephritis was the virus, and that "catching cold" had little to do in causing the kidney complication.

THE PRESIDENT expressed his belief that in many cases of scarlatina exposure to cold was productive of kidney disease.

FOURTH DAY—SEPTEMBER 25TH.

DR. F. FORCHHEIMER, of Cincinnati, read a paper on "The Etiology of Stomatitis Aphthosa," presenting the following conclusions:

Stomatitis is a disease produced by some form of deleterious material in the circulation, which may have its origin in various processes, bacterial or otherwise.

The action of this material is expended upon a nerve or nerves, upon a nerve-center or nerve-centers, and occasions an herpetic eruption that is the aphthous process.

A committee was appointed, consisting of Dr. F. Forchheimer and the President, to consider the nomenclature of the diseases of the mouth in children.

DR. J. H. FRUITNIGHT, of New York, read a paper entitled, "Perityphlitis in the Young," in which he summarized the treatment as follows:

In cases of chronic or subacute perityphlitis, without a tumor or with a small tumor, an expectant plan of treatment should be adopted. When there is a growing tumor, with or without evidences of suppuration, extra-peritoneal incision or aspiration should be performed.

In cases of acute perityphlitis, with threatening symptoms, with tumor, and in subacute cases without tumor, exploratory incision (either peritoneal or intra-peritoneal) should be made.

The officers elected for the following year were:

President.—Dr. William Osler, of Baltimore.

Vice-President.—Dr. J. M. Keating, of Philadelphia.

Secretary.—Dr. S. S. Adams, of Washington.

Treasurer.—Dr. C. W. Townsend, of Boston.

Recorder.—Dr. W. P. Watson, of Jersey City.

Dr. W. D. Booker, of Baltimore, was admitted to the Council.

The Society then adjourned, to meet in Boston in May, 1892.

CORRESPONDENCE.

EDITORIAL DEPENDENCE.

To the Editor of THE MEDICAL NEWS,

SIR: Reading the excellent editorial in THE MEDICAL NEWS of September 12th, on commercialism in relation to the medical press, calls to my mind an incident that in this connection I think is worth relating.

I was very much interested in a series of public meetings held in St. Louis last summer by a paranoic who posed as an evangelist. The interest from a medical standpoint attached to the fact that the phenomena of hypnotism were exhibited in many that attended the meetings.

The editor of a certain medical journal, having learned that I had made some study of the meetings, addressed me a very polite note asking me to prepare a paper upon the subject for his journal at an early date. At the same time he himself wrote a very sensible and vigorous editorial denouncing the meetings as exerting baneful effects upon the mental and moral health of the community.

I at once accepted the invitation and immediately set about writing the paper, so that it might appear at an early date. The next morning I received another note (also a polite one) from the editor, saying that he sincerely regretted that it was necessary to withdraw the invitation he had extended to me the day before, as the publishers of the journal were strongly averse to his editorial and desired that the journal have nothing further to say about the meetings. He assured me that personally he regretted that he would not be able to carry out his original design. *Homo alieni!*

I, however, continued the preparation of the paper, and when it was finished sent it to THE MEDICAL NEWS, in which journal it was promptly published (September 27, 1890).

THEODORE DILLER.

NEWS ITEMS.

A Prize for a Work on Demography.—At the conclusion of the Seventh Congress of Hygiene and Demography it was announced that Dr. Kőrösi had offered a prize of 1500 francs (\$300) for the best work on the subject of demography and its progress in the chief countries of Europe and the United States. Essays, which must be written in English, German, French, or Italian, must be sent by January 1, 1894, to the Permanent Committee of the Congress. The name of the author is to be sent with the essay, but in a sealed envelope. The paper will be examined by an international committee of five statisticians elected by the Permanent Committee, but not necessarily members of it. The prize will be awarded at the opening meeting of the next Congress of Hygiene and Demography at Budapesth.

Zeitschrift für Orthopaedische Chirurgie Einschliesslich der Heilgymnastik und Massage is the name of a new periodical edited by Dr. Albert Hoffa, of Würzburg, the first number of which has just appeared. The name of the journal indicates the objects to which it will be devoted. It is intended to replace the *Centralblatt für Orthopädische Chirurgie*, hitherto under the editorial care of Dr. Beely, of Berlin. Four numbers (of which from four to six will appear annually) will constitute a volume.

The Fourth Italian Congress of Internal Medicine will be held at Rome, October 19, 20 and 21, 1891. Professor Baccelli will preside. Rossoni and Forlanini will read a paper on The Pathology and Treatment of Diseases of the Stomach; Albertoni and Queirolo will read a paper on The Pathology and Treatment of Auto-intoxications; Patella and Mya will read a paper on The Various Forms of Icterus.

Dr. J. W. S. Gouley will deliver a series of lectures on Diseases of the Urinary Apparatus, on Tuesdays, at 8.30 P.M., beginning October 6th, at the Mott Memorial Hall, 64 Madison Avenue, New York. These lectures, supplemented by clinics at the Bellevue Hospital, will be free to the profession and to students of medicine.

Prof. Maydl, of Vienna, has been elected Professor-Ordinary of Surgery at Prague.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM SEPTEMBER 15 TO OCTOBER 5, 1891.

VOLLUM, EDWARD P., Colonel and Chief Medical Purveyor.—Retirement from active service is announced.—S. O. 211, A. G. O., Washington, D. C., September 11, 1891.

CRAMPTON, LOUIS W., Assistant Surgeon.—Is relieved from duty at Fort Sheridan, Ill., and ordered for duty at Fort Townsend, Washington, relieving James C. Worthington, Assistant Surgeon. Assistant Surgeon Worthington, on being relieved, is ordered to Fort Thomas, Ky., for duty at that station, relieving George M. Wells, Assistant Surgeon. Assistant Surgeon Wells, on being relieved from temporary duty at Fort Thomas, Ky., is ordered to San Carlos, Arizona, for duty.

KEAN, JEFFERSON R., Assistant Surgeon.—Granted leave of absence for three months, on surgeon's certificate of disability.

WELLS, GEORGE M., Assistant Surgeon.—Relieved from duty at Columbus Barracks, Ohio, and ordered to Fort Thomas, Ky., for temporary duty, relieving Henry I. Raymond, Assistant Surgeon. Assistant Surgeon Raymond, on being relieved, will re-

port to the commanding officer Fort Robinson, Nebraska, for duty at that station.

DEWITT, THEODORE F., Assistant Surgeon.—Granted leave of absence for six months, on surgeon's certificate of disability.

KIMBALL, JAMES P., Surgeon.—Relieved from duty at Fort Supply, Indian Territory, and ordered to Fort Clark, Texas.

PATZKI, JULIUS, Surgeon.—Relieved from duty at Fort Huachuca, Arizona Territory, on expiration of present sick-leave, and ordered to Fort Supply, Indian Territory.

ALEXANDER, CHARLES T., Colonel and Chief Medical Purveyor.—Relieved from the duties of Attending Surgeon and Examiner of Recruits in New York City, and assigned to the charge of the Medical Purveying Depot in that city.

FORWOOD, WILLIAM H., Surgeon.—Granted leave of absence for one month, on account of sickness.

EWING, CHARLES B., Assistant Surgeon.—Will continue on duty as Attending Surgeon and Examiner of Recruits at St. Louis, Mo.

CROSBY, WILLIAM D., Assistant Surgeon.—Relieved from duty at Fort Pembina, North Dakota, and ordered to Fort Missoula, Montana, for duty.

REED, WALTER, Captain and Assistant Surgeon.—Relieved from duty as Attending Surgeon and Examiner of Recruits at Baltimore, Md., and ordered to Fort Snelling, Minnesota, upon completion of his duties as a member of the Army Medical Board.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF THE MEDICAL CORPS OF THE U. S. NAVY FOR THE WEEK ENDING OCTOBER 3, 1891.

HALL, J. H., Surgeon.—Placed on the Retired List, September 25, 1891.

TURNER, THOMAS J., Medical Director.—Placed on the Retired List, September 21, 1891.

BOYD, JOHN C., Surgeon.—Ordered to duty on the Naval Medical Examining Board.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE-HOSPITAL SERVICE, FOR THE SIX WEEKS ENDING SEPTEMBER 19, 1891.

PURVIANCE, GEORGE, Surgeon.—Granted leave of absence for thirty days, August 22, 1891.

LONG, W. H., Surgeon.—Granted leave of absence for twenty-two days, August 18, 1891.

AUSTIN, H. W., Surgeon.—To proceed to Delaware Breakwater Quarantine Station, as Inspector, August 28, 1891. Granted leave of absence for thirty days, September 3, 1891.

GASSAWAY, J. M., Surgeon.—Granted leave of absence for ten days, September 19, 1891.

STONER, G. W., Surgeon.—Granted leave of absence for ten days, August 15, 1891.

CARTER, H. R., Passed Assistant Surgeon.—To proceed to Cape Charles Quarantine for temporary duty, August 27, 1891.

WHEELER, W. A., Passed Assistant Surgeon.—To proceed to Cape Charles Quarantine for temporary duty, August 27, 1891.

BANKS, C. E., Passed Assistant Surgeon.—Granted leave of absence for eleven days, September 3 and 9, 1891.

CARMICHAEL, D. A., Passed Assistant Surgeon.—Leave of absence extended thirty days, on account of sickness, September 10, 1891.

GLENNAN, A. H., Passed Assistant Surgeon.—Granted leave of absence for seven days, August 29, 1891.

GUIERAS, G. M., Assistant Surgeon.—Relieved from duty at San Francisco, Cal.; to proceed to New Orleans, La., for special duty, September 14, 1891.

WERTENBAKER, C. P., Assistant Surgeon.—Granted leave of absence for thirty days, September 10, 1891.

PERRY, J. C., Assistant Surgeon.—To proceed to Evansville, Ind., for temporary duty, September 18, 1891.

YOUNG, G. B., Assistant Surgeon.—Granted leave of absence for eight days, August 29, 1891. To proceed to Cairo, Ill., for temporary duty, September 15, 1891.

HOUGHTON, E. R., Assistant Surgeon.—To proceed to Vineyard Haven, Mass., for temporary duty, August 29, 1891. Granted leave of absence for sixty days and permission to go abroad, September 18, 1891.

PROMOTION.

GOODWIN, H. T., Assistant Surgeon.—Commissioned as Passed Assistant Surgeon September 18, 1891, to date from September 24, 1891.